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BEING PREGNANT AND USING DRUGS:
A RETROSPECTIVE PHENOMENOLOGICAL INQUIRY

by

Merry A. Armstrong, MSN

A dissertation presented to the
FACULTY OF THE PHILIP Y. HAHN SCHOOL OF NURSING
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requirements for the degree
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April, 1992

Abstract

Being Pregnant and Using Drugs: A Retrospective Phenomenological Inquiry

Qualitative methodology was employed to conduct a phenomenological inquiry describing the structure of the experience of being pregnant and using drugs. The purpose of the study was to explore the nature of women's experience and perception of the interaction, relationship, and intersection of contextual phenomena of lifestyle, pregnancy, and substance abuse. Data gathering and analysis was accomplished using guidelines provided by Spiegelberg and Van Manen.

Eleven mothers voluntarily participating in a recovery program described their prior experience of being addicted and pregnant during 2 conversations with the researcher. Through transcript analysis of the first audio-taped interview, major and minor themes describing the phenomena emerged. During the second interview participants clarified, offered additions or corrections, and thereby verified the findings of the study. Major themes synthesized with minor themes were;

1. Experiencing pregnancy included intentional pregnancy to create or extend a family, and accidental pregnancy, welcomed or unwelcomed.
2. Experiencing addiction and pregnancy was generally

use, acting "not pregnant", involvement in a chaotic lifestyle, experiencing pleasant and unpleasant fantasies about the baby, fantasizing that pregnancy would curtail addiction, and feeling guilt and self deprecation related to using drugs.

3. Experiences of self included extreme social and emotional isolation, mistrust of others, and difficulty managing emotional issues.

Using phenomenological methodology, participant's experiences were individually and collectively analyzed and integrated to produce the following composite structure of the universal experience of being pregnant and using drugs as discovered in this study;

Being pregnant and using drugs was a physical, intrapersonal and interpersonal transforming experience that occurs within an isolative addictive lifestyle characterized by mistrust of others, risk-taking, deception, and self-deprecation. Use of drugs incurred feelings of guilt and self-hatred while paradoxically assuaging loneliness, and distancing and dissipating negative feelings. A pervasive lack of connectedness to and positive meaning of one's pregnancy manifests in the experience of bringing a child into the world not wholly welcomed.

The findings in this study provide a beginning description of the meaning of the experience of being pregnant and using drugs.

April, 1992 Merry A. Armstrong

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DEDICATION

This dissertation is dedicated to all of my family and friends who have made life as an adult student possible. A bounty of love and encouragement has been inspiring and enabling - Thank you.

This dissertation is also dedicated to Marion Hubbard who made pursuit of this degree and scholarship a possibility. Thank you, Marion, for your dedication to nursing. Be assured that your significant contribution to scholarship will endure.

I would also like to dedicate this dissertation to my co-researchers, participants in the study who despite their own problems were proud to be helping others.

To all who have helped me over the years through writing and re-writing, my grateful thanks. To my dissertation committee who contributed helpful suggestions and embodied the concept of collaboration, highest regards.

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CHAPTER 1

Substance use and abuse is rampant in today's society. Once thought of as confined to persons of lower socio-economic class, drug abuse is in fact practiced by persons of all social strata, geographic boundaries, and cultural backgrounds (Zinberg, 1985). For the population at large, admissions to hospitals for chemical dependency increased by 27% from 1980 to 1986 ("News in Mental Health," 1989), and Abelson & Miller (1985) estimate that 5 million Americans use cocaine reguarly. Clearly, drug abuse is a significant social phenomena of deep concern to health care professionals and lay persons alike.

A segment of the population at high risk for the harmful effects of drug use are pregnant women and their offspring. The magnitude of drug use in the pregnant population is reflected in the estimate that at least one in every ten American infants is exposed to drugs before birth (Chasnoff, 1988). Rarely quantified, drug use among pregnant women is acknowledged as commonplace (Hinds, 1990).

Although a high prevalence of drug abuse and pregnancy is recognized, there is a paucity of literature that addresses and explores the dual phenomena of pregnancy and

substance abuse from the perspective of the mother. Substance abuse in this study is defined as compulsive use of a drug despite adverse social, physical, and psychological effects (Naegle, 1988).

Substance abuse in the perinatal population has rapidly become a problem of such magnitude that the perinatal care network has been unable to keep pace in addressing or anticipating patient needs ("Newborns the victims," 1989; Weinstein, Gottheil, Smith & Migrala, 1986). Examples of the gap between need and reality are lack of information in the professional community about the care of the pregnant substance abuser, and absence of any facilities or appropriate treatment facilities for these patients in many areas (Chasnoff, 1991).

Lack of appropriate inpatient facilities exists due to several factors. Medical withdrawal of the pregnant individual differs significantly from that of the nonpregnant individual. Withdrawal from or use of drugs during pregnancy can cause placenta previa, uterine rupture, precipitous delivery, and fetal demise (Martin et al., 1988). The health care professional treating the pregnant woman in essence treats two individuals, and is at risk for liability should the treatment fail and result in fetal loss. Given the litigious climate of today's health care environment as well as lack of reimbursement from certain payor classes to cover intervention and treatment, programs

to manage withdrawal from drugs of abuse have not been widely developed. Patients are also fearful of exposure as drug users, wishing to avoid public censure and involvement of child protective agencies. It is no wonder that physicians are reluctant to question or confront patients about drug use, not wishing to invite litigation, insult or estrange their clientele (Martin et al., 1988). In addition, community referral resources are meager in San Diego, rendering appropriate patient referral to alcohol or drug treatment programs difficult. Pregnant drug users have many support needs and individual physicians are not prepared to provide needed services.

Treatment intervention for the pregnant drug user must be multifaceted because pregnancy is both a physical and social phenomena. Successful drug intervention treatment for pregnant women was noted with combined medical and social programs (Fitzsimmons et al., 1986; Iennarella, Chisum, & Bianchi, 1986). Despite documented success, society has been slow to designate funds for such programs, citing lack of budgeted funds for prevention programs.

Although prevention programs are costly, an estimated \$19,000 to \$28,000 dollars are spent per day for each neonate in intensive care units treating them for problems related to maternal substance abuse ("Facts on perinatal", 1989). In addition to immediate health care needs of affected neonates, long reaching effects of maternal

substance abuse on children are neurological and developmental deficits (Le Draoulec, 1992), seizure disorders (Oro & Dixon, 1987), and problems related to alteration in the usual attachment and bonding processes between mother and infant (Burns, 1986). Women's drug problems often begin before they are pregnant, and although pregnancy is given as a reason to stop using drugs, many complex forces act to sustain drug use.

In general, numerous reasons are given for use of substances including succumbing to peer pressure, engaging in normative adolescent behavior, maintaining relationships with significant others who use drugs, coping with multiple roles, escaping pressures, and obtaining narcissistic fulfillment, all of which will be explored at a later point. Specific information about women and substance abuse is limited, however it is obvious that some drug use issues, including pregnancy and substance abuse, are uniquely women's concerns. Other aspects of drug abuse specific to women are abuse of prescription drugs (Gomberg, 1986), and societal tolerance of women's medicinal drug use (Ehrenreich & English, 1978).

Acceptable behaviors for the pregnant individual including alcohol and drug use are socially derived (Gomberg, 1986). For example, as a result of relatively recent legislation, warnings accompany alcoholic beverages which caution pregnant individuals against drinking, and

women who drink while pregnant are subject to social disapproval. Likewise, because smoking is known to produce low birthweight infants, women who smoke during pregnancy are also subject to disapproval (Bry, 1983). To avoid detection, a pregnant woman engaging in socially prohibited behavior may do so in private, or with select company. Thus, public social injunction may not occur and approbation may be accorded to the pregnant individual within her own peer group.

Whether pregnant or not, women are exposed to and influenced by societal attitudes and practices regarding drug use. American society promulgates the use of drugs for pain relief, protection from infection, and other assorted ills, and children are acculturated to believe in the magic of medicine (Leininger, 1978). Society encourages the "quick fix" that medicines or drugs can provide (Gomberg, 1986).

A brief examination of popular advertising demonstrates societal proclivity toward the use of drugs. Media encouragement of drug use in our society is pervasive, subtle, and insidious. For example, review of a recent sports journal (Sports Illustrated, January 1990) revealed that 26 out of 53 advertisements were for alcohol or cigarettes. The message conveyed is one of sanction and approval toward use of these substances. In a magazine devoted to the endeavor of sports, it is particularly

confounding to find advertisement saturation for alcohol and cigarettes. Like other citizens, women are influenced by societal norms. But unlike half of the population, pregnant women's drug use immediately and profoundly affects another.

Statement of the Problem

Large bodies of literature and research explore the separate experiential phenomena of pregnancy and addiction. Lacking, however, are data which consider the combined experiences of drug use and pregnancy. Many studies focused on outcome effects of the fetus (Golden, Kuhnert, Sokol, Martier, & Williams, 1987; Kaye, Elking, Golbert & Tytun, 1989; Oro & Dixon, 1987; Telsey, Merrit, & Dixon, 1988; Thatcher, Corfman, Grosso, Silverman & DeCherny, 1989; Verklan, 1989; Zuckerman et al., 1989), but thus far there is a paucity of information on the experience of the mother during her pregnancy (Lindenberg, Alexander, Gendrop, Nencioli, & Williams, 1991). Additionally, review of the literature demonstrates that many studies related to substance abuse occurred in the 1960s and 1970s. Drugs of abuse have changed, and societal expectations have also changed. Data gathered about substance abuse from studies 20 and 30 years ago may not be valid in 1992. Current information is needed about the experience and motivation of women abusing drugs while pregnant. The primary question is, therefore: What is the nature of the experience of

concurrent pregnancy and drug use?

The experience of the pregnant abuser emerges as a significant subject of inquiry. The purpose of the study is to explore women's experience and the nature of interaction, relationship, and intersection of contextual phenomena of lifestyle, pregnancy and substance abuse.

Research Questions

Women who use drugs while pregnant experience pregnancy and concurrent drug use. What is the nature of the experience of the substance abusing woman who is also pregnant? The study will contact, evoke, describe, and elaborate the experiences of women who used drugs while pregnant. Themes that emerged from participant's described experience provided a statement of the formulated structure of the experience of women who used drugs while they were pregnant.

Assumptions

The assumptions of the present study are:

1. Women who used drugs while pregnant are able to describe events, situations, and people.
2. The descriptions are representative and reflective of the participant's experiences as they were lived.

3. Written transcriptions are reflective of the descriptions of the lived world of the participants.
4. Women who use drugs while pregnant experience pregnancy similarly to other pregnant women.
5. Drug use has physiological, psychodynamic, and sociocultural aspects.
6. The researcher's clinical background favors psychological understanding and meaning of phenomena.

Significance of the Study

Many women who deliver infants prenatally exposed to drugs do so without the benefit of prenatal care. Patients using drugs during pregnancy may not seek prenatal care because of fear of discovery or lack of resources (Chasnoff, 1990). For example, in San Diego County, a minority of physicians accept obstetric patients receiving public assistance because of reimbursement issues. Additionally, few medical withdrawal facilities exist in this community for pregnant patients in any payor class. If any patient, regardless of payor status, wishes to be medically withdrawn and needs to be an inpatient, there is simply nowhere to go. Thus, when the patient delivers, she delivers as a high risk patient and delivers an infant at risk for immediate and

long term problems. Overwhelming problems resulting from drug abuse during pregnancy, staggering costs to human life, and burdens on the health care system require a societal mandate supporting development, implementation, and evaluation of preventative programs to mitigate this problem.

Exploration of the experience of the pregnant woman using drugs provides a perspective on the social and cultural contexts in which abuse takes place, and informs professionals designing prevention programs. Elucidation of the experience of substance using pregnant women may provide health care professionals information about what programs are appealing to the pregnant abuser. The actual experiences of mothers need to be heard in order to approach understanding the phenomena (Chodorow & Contratto, 1982).

In addition, information is needed about optimal timing within a recovery setting of therapeutic modalities and/or support services such as individual counseling and educational training to this underserved population (McBride, 1986). Without such information, health care professionals are without guidance in providing therapeutic interventions, developing programs, or initiating support services necessary to meet the needs of this population. Further, data describing the evolution of social role expectations and experiences may provide impetus for future research.

CHAPTER 2

Review of the Literature

The phenomena of pregnancy and substance abuse can be examined using numerous theoretical and practical approaches. The argument could be made that many interrelated themes applicable to pregnancy and substance abuse are researched in literature, and that personal bias informs the researcher's selection of choices of themes or frameworks. Acknowledging this process, I propose three themes germane to the issues; substance abuse, pregnancy, and feminist issues. Limiting the literature review to these areas does not preclude the discovery of other important relevant material during the research process, or define the phenomena bound by these concepts. Rather, it is necessary to define beginning points to inquiry (Spiegleberg, 1976). The literature review describes prevailing opinion and findings in these artificially separated areas and processes. In reality, it is impossible to consider dynamic processes as separate and doing so does not describe the contextual complexity of lived experience. Each theme will be reviewed separately, and interrelationships will be identified as they appear.

Feminist critique will be woven throughout the review.

Substance Abuse

Limitations of Review

Questions about the etiology of substance abuse have been posed from many theoretic approaches. Models of biology and genetic influences, hereditary or constitutional traits, disease, psychodynamic and psychoanalytic functioning, family systems, and sociocultural influences have been suggested and explored. Few of these major etiologic models have been sufficiently developed as complete theories, (Naegle, 1988), or have studied women (Hser, Anglin & McGlothlin, 1987a), but they are helpful in organizing inquiry and encourage "...thoughtful speculation..." (Naegle, p. 3) about the structure of substance abuse problems. According to Peele (1985), a successful model of addiction must,

...synthesize pharmacological, experiential, cultural, situational, and personality components in a fluid and seamless description of addictive motivation. It must account for why a drug is more addictive in one society than another, addictive for one individual and not another, and addictive for the same individual at one time and not another. (p.72)

It is easy to see why one comprehensive theory of addiction has remained elusive. In addition, says Peele (1985), theories of addiction must be "...faithful to lived human experience." For example, lived human experience suggests that single or multiple exposures to a drug does not create

an addict. Also, as individuals are subject to different social forces, a theory must also address the importance of those forces. Addiction is a complex phenomenon and consideration of one model as wholly explanatory produces simplistic and inaccurate ideas about addiction (Zinberg, 1984).

Addiction as a concept has a long history. The term did not originate in relation to a drug or substance. Zoja (1989) traced the term "addiction" and discovered etymological roots in the Latin word "'addictus', meaning handed over (to someone) as a slave." (p.29). Over time, the meaning of the word came to be connected with the use of drugs. Zoja said;

Etymologically speaking, 'addiction' is a phenomenon not automatically connected with substances, but with the ultimate corruption of substances by those who expect archetypal, magical, ritual, and esoteric results from them. One gives oneself over to a substance which comes from afar and, in the expectation of the user, is supposed to carry one far away (p.29).

Zoja acknowledged biological addiction and also considered substance use as a ritualistic behavior which has replaced the ritual practices of our ancestors. Peele (1985) considered drug use a repetitive compulsive activity which becomes in itself an addiction. Since addiction is a complex phenomena not explained by one model, a synthetic framework of addiction will be utilized for this research. Predominant frameworks are Khantzian's theory of self medication (1985), and feminist theory (Chodorow, 1978;

Ehrenreich & English, 1978; Eichenbaum & Orbach, 1987; Gilligan, 1977; Miller, 1986).

Because of wide applicability and currency of the framework, Khantzian's (1985) theory of drug abuse as self medication will be discussed. Khantzian's (1985) theory is analytically based in that he utilized analytic intrapsychic structures such as the unconscious, and the ego. I chose this model not because I subscribe exclusively to analytic theory. However, I am a product of our educational and cultural processes in which analytic terminology and assumptions have become firmly embedded (Lerman, 1987). Therefore it is difficult for me to consider psychology and behavior absent psychoanalytic constructs of intrapsychic structure such as the ego and the unconscious.

Khantzian's theory (1985) suggests that although addiction is an individual's problem, addiction is also mediated by contextual variables. This aspect of his theory contributes to consideration of addiction phenomena beyond the boundaries of one individual. After considering various models of substance abuse I believe that when integrated with other theories, Khantzian's theory (1985) best applies to a range of abuse situations from the perspective of lived human experience.

Since the present study deals with substance abuse during pregnancy, it is logical to focus a review of literature on women's experiences. However, it is

impossible to limit review only to information about women because many studies explicating phenomena of drug abuse used only men as subjects. This reality, Bry (1983) points out, has limited our understanding of women's patterns of substance use and recovery. For example, drug and alcohol treatment programs, based on existing knowledge of addiction, were designed initially by and for men, and admitted women as an afterthought (Mondanaro, 1988). Indeed, says Cushner (1981), in 1980 the United Nations sponsored the World Conference for the United Nations Decade for Women. "This was the first instance, of which I am aware, in which the UN or any international organization included health among women's issues in a major conference. (p.214). Beyond gender issues, substance abuse is a phenomenon of both sexes and found in many cultures. Therefore, it can be reasonably assumed that some elements of drug use and abuse are commonly shared by men and women.

Khantzian's Theory

Khantzian (1974, 1975, 1985) evolved a psychodynamic theory of substance abuse which addressed the personality organization of the drug user as the key to abuse. His ideas about substance use appeared in the 1970s, when environmental and pharmacologic explanations of abuse were disputed (Compton, 1989, Gomberg, 1986). Using a different framework than his predecessors in formulating his theory,

he drew upon the subjective experiences of addicts (Khantzian, 1985). He felt that people selected and used drugs to medicate themselves for a variety of painful psychiatric problems and painful affective states, not for "...escape, euphoria, or self-destruction (Khantzian, 1985, p. 1263)". Also unlike his predecessors, Khantzian viewed drug abuse as an attempt to cope with dysphoric emotional states, not as pleasure seeking activity. He and his associates incorporated psychoanalytic thinking in applying object relations theory and developmental issues and substance abuse. Therapists in a program for pregnant substance abusers subscribed to Khantzian's philosophy (Chasnoff, 1986) and found his framework helpful in conducting individual therapy with clients.

Psychodynamic approach.

While not refuting other theories, Khantzian thought a psychodynamic approach emphasizing developmental and adaptive factors appropriately applied to addiction phenomena. Developmental and adaptive factors affected the experience and regulation of feeling states (or affects), self esteem, relationships, judgement and behavior, and the capacity to manage stress (Treece & Khantzian, 1986). His theory was not limited to any particular substance of abuse but suggested a general framework for psychodynamic understanding of substance dependence by considering

personality as the underlying key to abuse.

Khantzian (1985) acknowledged that drug abuse must be considered within the patterns of cause and effect phenomena over time, as patterns created by drug use create social, physiologic and developmental consequences which may perpetuate the behavior. He did not seek to simplify or minimize the reality of multiple contextual variables at work in initiating, maintaining, and perpetuating the circular affective discomfort/relief cycle of substance abuse, or suggest that abuse and character pathology are linearly equated or quantifiable. But he claimed that one of the most compelling reasons to use substances was relief of acute psychic pain.

The inability to deal with psychic discomfort, or negative affects, was seen partially as a failure of ego functioning, termed a character disorder. Khantzian's theory utilized psychoanalytic concepts and therefore employed Freud's definition of the ego (Compton, 1989), referring to that part of the mind in contact with reality. The ego regulated the drives and instincts of the id and the moral forces of the superego. Intense affective states and low self esteem challenge the ego's ability to modulate psychic resources, important issues for women as will be seen. "Individuals self-select different drugs on the basis of personality organization and ego impairments" (Khantzian, 1985, p. 1260).

Predisposing vulnerabilities.

Three predisposing "vulnerabilities" to substance abuse were major difficulties in tolerating affects, vulnerability in self esteem and a range of disturbances in thinking and judgment (Treece & Khantzian, 1986). The degree of difficulty in these areas was presented on a continuum, and the magnitude of drug use or dependence described as partially dependent on the nature and degree of one's location on the continuum in terms of intrapsychic difficulties. Khantzian acknowledged the additive effects of many variables, all of which cannot be identified or quantified (Treece & Khantzian, 1986). Considering substance dependence from this viewpoint offered an approach to the phenomena that included those who use drugs occasionally and those who became dependent, observed by Peele (1985), and Zinberg (1984).

Difficulties with management of emotional states were the most common observations of drug abusers in treatment, according to Treece and Khantzian (1986). Citing many examples, Treece and Khantzian (1986, p. 401) stated "...substances are used by the individual to bolster, support, and compensate for inadequate internal regulatory mechanisms including those for defense, self-soothing, and modulation of affect." Khantzian hypothesized that the need for a sense of control over intense affects lead to a

preference for the drug induced feelings that the user controlled, versus the sense of helplessness and unpredictability experienced without drugs. Failure to use feeling states as information to guide decision making was a related dynamic of the substance abusing individual.

Other features predisposing the individual to drug abuse were difficulties with closeness and maintenance of self-esteem. These features may be especially important in considering substance abuse among women, and will be discussed at a later point. Treece and Khantzian (1986) cited the inability to turn to and find comfort in others, fear of closeness involving fear of one's own aggression, and an intolerance of rejection or other disappointments in relationships to exemplify these difficulties.

Another dynamic, often resulting from the first two vulnerabilities, was impaired judgment and the failure of self care activities of the predisposed individual. Denial of the danger of drug use was noted (Khantzian, 1978; Treece & Khantzian, 1986). Theoretically, denial of danger emanated from impairment of early internalization of protective parental attitudes. Deficits in anticipating and avoiding harm were seen as a result of initial difficulties of using feelings as information, because extreme feelings produce personal disorganization. Disorganization lead to primitive defense mechanisms such as projection and narcissistic denial that resulted in the inability to assess

of harm. Further use of inappropriate defense such as externalization led to magical thinking which drew the substance abuser to use drugs as the search to and wish for reliance on external sources of comfort and conflict resolution. Chronicity and severity of drug use further deteriorates individual judgment.

Critique of Khantzian's theory.

Khantzian identified behaviors and feelings common to many persons who use substances. While his concept is narrowly applied to individual addicts, it is useful because it considered a continuum of behaviors emanating from the same theoretical foundation. Although he acknowledged that many factors external to the individual influenced drug dependence, he did not specifically discuss social aspects of substance abuse. While not perhaps germane to his model, I believe that in order to examine substance abuse, one must address social issues, in this case women's issues.

Original psychoanalytic thinking, like much of psychology, framed women's reality against that of the reality of men, a natural occurrence since the theory originated in a male dominated society (Ehrenreich & English, 1978; Eichenbaum & Orbach, 1987; Lewis, 1986). Psychoanalytic thought serves to perpetuate the notion of a conflicted relationship between mother and infant that does not develop as healthy and mutually satisfying (Lerner,

1988). The father was not included in analytic interpretation of very early development, and the constitutional, hereditary, psychological, and biological resources of the child were not considered as factors in dynamic interaction (Caplan & Hall-McCorquodale, 1985). Khantzian's theory, developed to psychodynamically address all addictions, did not refute this thinking, although he alluded to social and cultural influences in substance use.

Newer ideas evolved from psychoanalytic thinking acknowledged importance of the father and considered his influence on child development (Lerner, 1988; Lewis, 1989). Khantzian's theory reflected recent psychoanalytic thinking, including psychostructural developmental processes of object relations and ego development. "Object relations" referred to developmental achievements of differentiation of self from others (Lerner, 1988; Nighorn, 1988). Central to object relations and ego development were feelings of vulnerability, weakness, helplessness, dependency, and emotional connections between people (Miller, 1986; Mirin & Weiss, 1986; Treece & Khantzian, 1986).

...psychoanalysis has in a very large sense been engaged in bringing about the acknowledgement of these crucial realms of the human experience. It has done this, I think, without recognizing that these areas of experience may have been kept out of people's conscious awareness by virtue of their being so heavily dissociated from men and so heavily associated with women. (Miller, 1986, p. 23)

The social system itself is defined as pathological, not necessarily the individuals functioning within the society.

Further, if narcissistic and object relations patterns were arrested in infancy as classic analytic thought professed, they are resistant to change through experience or psychological insight. This concept precluded change and development as adults occurring through maturation and insight (Miller, 1986).

Women's Issues and Drug Use

Because the body of literature on substance abuse is vast, when possible the literature review will be limited to information about drug abuse pertaining to women. As has been stated, observation and research about drug use began with studying the phenomena with men. Women have been adjuncts to that study (Mondanaro, 1988). Despite a high rate of alcoholism among our population, women represent less than 20 percent of the clients in federally funded drug and alcohol programs (National Council on Alcoholism, 1988). Van Den Bergh (1991) cites 4 reasons why women are underrepresented in recovery programs; lack of financial resources, responsibility for child care, the stigma of being female and addicted, and pejorative attitudes towards women. An additional item, the stigma of being pregnant and addicted, might be added to the original list.

Statistics indicating prevalence of substance use are estimates because of the numbers of "hidden" users. Complicating the issue, women do not seek help for drug

problems, but for the problems that lead to drug use, for example, depression or somatic complaints (Mondanaro, 1981, 1988). Although reluctant to do so, physicians need to pursue physical complaints that may stem from substance use and to investigate these symptoms with their patients (Peluso & Peluso, 1988). A study by Matera, Warren, Moomjy, Fink, & Fox (1990) investigated prevalence of cocaine and other substances in the urine of all women who presented for delivery. Ten percent of the study population (n=509) were positive for cocaine, 13% positive for amphetamines. The researchers discovered that the medical history predicted only 37% of cocaine positive screens and none of amphetamine positive screens. Their findings highlighted the importance of careful examination and interview of pregnant women.

While many women seek medical intervention for physical complaints due to substance abuse, most men seek intervention for alcoholism because of external difficulties such as encouragement by spouse, legal intervention, or coercive intervention from work, (Beckman & Amaro, 1984). Thus, patterns of medical intervention in the United States and women's reproductive needs increase the likelihood of women receiving more prescription drugs than do men (Gomberg, 1986). Bush, McBride, & Buenaventura (1982) conducted a study in which female respondents indicated that they used drugs and alcohol to deal with the emotional pain

of infertility or relief of pelvic pain.

Historically, prescription drugs have not been considered illicit (Gomberg, 1986). Taking "medicine" for physical complaints has been legitimized in our society (Bry, 1983; Ehrenreich & English, 1978; Gomberg, 1986; Hser, Anglin & McGlothlin, 1987a). Up to 1914, laudanum (an opiate derivative) could be ordered from Sears and Roebuck for 9 cents an ounce (Gomberg, 1986), and the majority of opiate users were women (Hser, Anglin & McGlothlin, 1987a). Both Gomberg (1986) and Bry (1983) attributed early patterns of women's drug use to frustration and boredom of middle class women's lives and role changes subsequent to the industrial revolution. Ehrenreich & English (1978) also correlated dispensing of prescription drugs to women with the rising power of (male) physicians during the early 1900s.

Codependence and women's issues.

The syndrome of codependence has become a subject of many articles, self help groups, books, and interest in our society (Kaminer, 1990; Krier, 1990). Codependence is a syndrome of behaviors emanating from childhood experiences. The child in a dysfunctional family learns quickly that in order to survive, rapid adaptation to many situations and people is required. In accomplishing chameleon-like adaptation, the child suffers a loss of identity. In a

dysfunctional family, children do not receive verifying support from parents promoting validation and identification of their own feelings and needs (Eichenbaum & Orbach, 1987; Peluso & Peluso, 1988). The child develops unhealthy patterns of coping as a reaction to another's alcohol or drug problem (Zerwekh & Michaels, 1989).

Cermak (1988) listed diagnostic criteria for codependence including assumption of responsibility for meeting other's needs before one's own, anxiety and boundary distortions around intimacy, enmeshment in dysfunctional relationships, and maintenance of self esteem by control in situations where control may not be indicated. Other symptoms are excessive denial, depression, hypervigilance, anxiety, substance abuse, stress related medical illness, primary relationships with substance abusers, and constriction of emotions.

Many features of codependency and dysfunctional behavior, especially relational descriptors, are synonymous with Miller's (1976) description of women's behavior in our culture. She attributed women's patterns of assuming responsibility for others as a result of the complex interplay of gender, power groups, and society. Interestingly, Miller's work examined psychological dynamics of women's lives and did not explore addiction phenomena. However, her work presaged the popularization of codependency information when she spoke of women's roles in

society; pleasing others, subjugating one's needs for others, taking refuge in substances, feeling little self-esteem, and little self identity. Assuming a culturally supported subordinate position, the woman sacrificed her identity to nourish others around her. Codependence as defined by Cermack (1988) fits women's roles in our culture as described by Miller (1976).

Explaining cultural relationships and adding another perspective to Miller's observations, Chodorow (1978) stated, "In any given society, feminine personality comes to define itself in relation and connection to other people more than masculine personality does (p.187). Eichenbaum and Orbach (1989) described the development of women's relational patterns;

In absorbing the emotional imperatives that are to be women's way of being, we learn not only to be giving, intuitive, receptive, caring, empathic, we learn too that it is ungrammatical to be separate, initiating, autonomous, and self-defined. These ways of being are considered undesirable in girls. (p.54)

Modanaro (1988) believed that the concept of codependency has outgrown its original application to relationships within the drug and alcohol context. Like Miller (1976), she described women's roles as supporting dependency of others. Emanating from poor self esteem, the woman believed she was incapable of being loved: She settled for being needed. Within this context, drug and alcohol became easy vehicles to escape the pain of unsatisfying relationships and self disgust. Relationships

were formed with needy others and a dysfunctional system emerged. Integrating Khantzian's and feminist theories, women may seek relief of psychic pain by using drugs or other substances.

On a less personal scale, Kaminer (1990) believed that codependence symbolized "millennium fever" (p.8), and represented a general wish for rebirth and renewal also described by Zoja (1989). In recovery, everyone discovers their inner child, is reborn, and begins again. Poignant stories of individual addiction (Johnson, 1980; Peluso & Peluso, 1988) demonstrated relief from psychic or physical pain provided by substances. The escape from pain is joined with becoming a new person, without painful feelings (Peluso & Peluso, 1988);

I was so nervous I was shaking. The hostess came toward us with such confidence and poise. I started to say hello but all I could do was stammer. I went to the bar and asked for whiskey. After a few sips I felt better. After two drinks I was comfortable with everyone there. All the fear disappeared. I knew I had found some key to living. A couple of drinks and I was social and delightful. I was charming. I had confidence and poise. I was good enough. I didn't have to flip my life to make me acceptable. Drinking did the flipping for me. It was the great equalizer (p. 79).

These authors felt that drug use was especially seductive and quickly addicting for women.

Erickson and Murray (1989), responding to the notion that cocaine was cited as being more addictive to women, refute this claim. Loss of control, ever an injunction for women, was at the seat of society's distaste for the

intoxicated woman (Ehrenreich & English, 1978; Gomberg, 1986; Bry, 1983; Erickson & Murray, 1989).

The intoxicated woman may not be using substances alone. Many women who use substances have chemically dependent partners, and have been introduced to drugs initially by men (Rosenbaum, 1981; Eldred & Washington, 1975; Escamilla-Mondanaro, 1977). Hser, Anglin & McGlothlin (1987b) noted differences in trends of initiation of drug use by women themselves: White women used prescription drugs first, black women used street drugs first. Women voiced lower self-esteem than their male counterparts (Colten, 1981; Mondanaro, 1988), and often came from alcoholic or drug abusing households (Gomberg, 1986), perpetuating substance abusing behaviors.

Drug use in a childbearing population.

Increasing numbers of children born exposed to toxic substances has prompted an increase in research in substance abuse in the childbearing population (Abma & Mott, 1991). Harrison (1989) separated older (35 and over) and younger (under 35) women in substance abuse treatment programs to form 2 study groups. Separating the study population by ages achieved a rough correspondence to initiation of drinking and drug use and having achieved adulthood before cultural shifts occurred in the 1970s. Cultural shifts were descriptions of drug use prior to the 1970s as deviant

behavior to present descriptions of drug use among adolescents as normative adolescent experience. Findings of surveys of 572 women in 21 treatment programs located in 11 states revealed that younger women were significantly more likely to use marijuana, cocaine, stimulants, opiates, and hallucinogens on a weekly basis. One third of the younger women used marijuana weekly and one third used cocaine weekly. Serious symptoms appeared more frequently due to cocaine use; binge use, shakes, inability to stop using, absenteeism, and unusual behavior under the influence. No significant differences existed between age groups for frequent use of barbiturates, sedatives, hypnotics, tranquilizers, painkillers, and over-the-counter drugs.

Four times as many younger women began drinking before turning 16 (56% vs. 14%), and 47% of the younger women began using drugs by age 15 compared with 3% of the older women. Solitary drug use or drinking was significantly more common among older women. No significant difference existed between groups in frequency of reports of alcohol abuse by family members. Overall, 60% of the women reported alcohol abuse, and 40% reported drug abuse by a family member. Among women who had been married, drug abuse by the spouse was three times more likely in the younger group. Younger women report more alcohol-related job absenteeism, violence, drinking during pregnancy, and consumption of the equivalent of a fifth of liquor in a day.

Overall, 41% of the women reported a history of professional treatment for depression and 27% for another emotional disorder, significantly more common in younger women. Nine percent of all women said they had felt depressed for as long as they could remember. Thirty percent of all women made a suicide attempt, but attempts were more likely among the younger group. The younger group was also significantly likely to have experienced sexual abuse.

Harrison (1989) commented that the younger group presented a more complex array of recent problems and troubled histories than did the older women. The author explained that varieties of drugs are more widely available now than they were in the 1970s, and that generational differences may account for some of the findings. Additionally, older women who were involved in heavier drug use when they were younger may have been excluded because they may be in prison, hospitals, homeless, or dead. A response bias may have existed in that younger women might have been more willing to self-disclose drug behavior.

Amaro, Fried, Cabral, and Zuckerman (1990) studied 1,243 inner city prenatal clinic patients and discovered that 7% reported physical or sexual violence during pregnancy. The victim's use of alcohol and perpetrator's use of cocaine or marijuana were associated with increased risk of violence during pregnancy. Victims of violence were

at greater risk for having history of depressive symptoms, attempted suicide, having current symptoms of depression, reporting less happiness about being pregnant, and receiving less emotional support from others for the current pregnancy. Comparison of victims and non-victims indicated that victims were more likely to be users of alcohol and drugs.

Investigating chemical dependence and clinical depression in pregnancy, Burns, Melamed, Burns, Chasnoff, and Hatcher (1985) studied 54 pregnant women, into three age groups. The sample included 12 teenagers (age 17 to 19), 27 young adults (age 20 to 25), and 15 older adults (27 to 36). Over 50% were moderately to severely depressed. While only 8% of the teenage women and 25% of the young adult women were severely depressed, 60% of the older women were severely depressed. Most (81%) of the sample acknowledged opiate dependence and/or abuse, the other 19% were dependent on alcohol or another drug.

Do women change their patterns of drug use when pregnant? Johnson, McCarter, and Ferencz correlated data from 1,336 African-American and caucasian mothers regarding alcohol, cigarette, and recreational drug use prior to and during pregnancy. Nearly half of the study population refrained from using any substances during pregnancy. Of those, half restricted use to cigarettes and alcohol. Cigarette and recreational drug use was associated with

lower socioeconomic status, while alcohol use was associated with higher socioeconomic status. Recreational drug use and cigarette cessation were more common among professionals and college-educated women, but those same characteristics were associated with failure to quit drinking. Race was not associated with quitting of any substance.

Summary, Substance Abuse

Review of substance abuse literature reveals many theories postulated to explain why people initially use then continue to use and abuse substances. It is clear that aside from physiological dependence created once drugs are initiated, social and psychological factors contribute to initiation and continuation of use (Van Den Bergh, 1991). Relative importance of specific factors were debated, but consideration of substance abuse phenomena perforce includes psychodynamic, physiologic, and sociocultural aspects.

A large body of literature dealing with substance abuse was generated in the 1960s and 1970s. Because of changing trends of drug use and social roles, it is not clear what this research contributes to our understanding of current phenomena of drug use. Many research studies exploring substance abuse were done when common drugs of abuse were opiates. It is questionable that individuals use today's drugs in the same manner that opiates were abused (Redda, Walker, & Barnett, 1989). Also, studies of

individuals who abused drugs typically recruited subjects from recovery groups or institutionalized settings: The secret user was not studied. Prevailing opinion holds that since many women abuse substances privately and may never reach recovery centers, their motivation and experience is unexplored. Lack of research explicating women's experience regarding drug use emphasizes the need for further inquiry.

Childbearing

Pregnancy is a biological, sociological, cultural, and psychological event. Pregnancy has also been described as a developmental process (Valentine, 1982; Lederman, 1984; Rubin, 1984), a transition (Bergum, 1989), a crisis (Sherwen, 1987), and a event subject to medical intervention (Ahmed, 1981). Observing intersecting aspects of women's reproductive processes, Oakley (1979) noted that childbirth occurred uncomfortably at the crossroads of two worlds of nature and culture. Uncomfortable because reproductive events are accessible to many disciplines, resulting in conflicting priorities in the focus of care for the childbearing woman. Disciplines of medicine, psychiatry, anthropology, sociology (Artschwager, K., 1982; Arney, 1982) and nursing have approached childbearing phenomena, each have their own approach and evaluative emphasis and techniques.

It is important to recognize that only recently women

have reliable choices about reproduction provided by technology. The 1960s saw biological determinism refuted, and increased interest in motivations for motherhood.

Rowland (1987) wrote;

Women had children because they were socialized or conditioned to do so; because they were convinced of the rewards of mothering in order to gain a self-identity in a world that continually denied this to them; to prove their worth and attain the status of a 'mature adult'; or to consolidate a relationship. For many, motherhood represented a power base from which to negotiate the terms of their existence and survival. For many this is still the case. (p. 513)

Bergum (1989, p.54) stated that, "...the decision to become a mother is more complex than the rational decision-making process can encompass..."

Models of Childbearing

Several models are available which explore the developmental aspects of childbearing. Criticism of models emanates from institutionalization of childbearing and attendant social and cultural values inherent in constructed models. Nonetheless, it is helpful to conceptualize pregnancy and childbearing from several standpoints.

Utilizing naturalistic research methodology, Lederman (1984) interviewed 32 married primigravidas during the last trimester of pregnancy. The researcher identified seven dimensions of maternal development; acceptance of pregnancy, identification with a motherhood role, relationship with the pregnant woman's mother, relationship

with the husband, preparation for labor, prenatal fear of loss of control in labor, and prenatal fear of loss of self-esteem in labor.

Also using naturalistic inquiry to investigate childbearing, Bergum (1989) conducted a hermeneutic phenomenological study which posed the question, "What is the nature of the transformation of woman to mother" (p. 7.). Bergum (1989) interviewed 6 women extensively through pregnancy and the first few months of motherhood and discovered several thematic aspects of transformation. Each phase of childbirth, from contemplating having a child to actual childbearing included transformational aspects. Transformation was described as change that was deep, complex, and dramatic (p. 36). Although every woman experienced the childbearing process and event in different and often nonlinear ways, they were all nonetheless transformed by the experience of childbearing. Bergum's (1989) groupings of transformation are; the transformative experience of the decision to have a child, the transformative experience of the presence of the child, the transformative experience of birth pain, the transformative sense of responsibility, and the transformative experience of have a child on one's mind. Each theme of transformation comprised many essences, and of the complexity of describing these essences Bergum said (p.38);

There are mysteries surrounding the transformation of woman to mother which cannot, and perhaps should not,

be articulated. It is necessary, rather, to treasure the mystery while we try to grasp what can be revealed. Becoming a mother involves a movement from one mode of living to another; from woman without child to woman with child. That is straightforward, no mystery there. But attention to the 'movement' itself, the movement from one form of life to another, may reveal elements of transformation which are contained within the mystery - or perhaps it is a magic that is tied to the wonder at the strength of our relationship to our children.

Bergum thus spoke to the evoked silence of phenomenological writing, the silence that surrounds the description of an experience that can never be wholly described.

Other authors approached pregnancy and childbirth more narrowly, using a crisis framework. Valentine (1982) stated a first pregnancy constituted a genuine crisis requiring mobilization of all of the woman's resources, intrapsychic and extrapsychic. According to Valentine's review of current literature, four developmental tasks constitute major work for the expectant mother: Developing an emotional attachment to the fetus, differentiating self from the fetus, accepting and resolving the relationship with one's own mother, and resolving dependency issues. The author delineated tasks of expectant fathers, noting that further research was needed to identify developmental factors influencing each partner, individually and as a couple. The pregnant woman without a partner may experience additional needs in dealing with her pregnancy.

Other writers did not perceive childbirth as crisis, and thought using crisis terminology was not appropriate for

childbearing experiences (Ahmed, 1981). The sick role originally described in sociological literature was also considered inappropriate for application to childbearing (Ahmed, 1981; Arney, 1982), because 97% of women deliver babies safely (Oakley, 1979). Rubin (1982) approached maternal experience as a personal event located within a system of relationships and life experiences. Rubin's work was preceded by that of pioneer Deutsch (1945) who described psychological phenomena of pregnant women. Rubin expanded the work of Deutsch and created a model embracing the family or support structure of the pregnant woman. Rubin's framework, often referenced in nursing literature, will be explored as one available perspective examining the experience of the pregnant woman.

Rubin's Framework of Maternal Identity and the Maternal Experience

Rubin refuted the notion that childbearing behaviors were instinctual, and stated that instinctual explanation for maternal behavior stemmed from a lack of sufficient theory or understanding of the phenomenon. Using naturalistic research techniques, the researcher discovered commonalities in beliefs and behaviors that many childbearing women exhibited, defined the development of maternal identity, and outlined maternal tasks.

Maternal identity.

Feminine identity, according to Rubin, was firmly in place by the time the young woman reached adolescence, and formed the basis for maternal identity. Late adolescence occurred between the ages of 17 and 25, according to Rubin. The alignment of self in the world was characteristic of this phase of a woman's life, and occurred through silent organizational thinking and processing of information, by active experimentation with sexuality, and active exploration of the feminine self. A new personality dimension was incorporated as the young woman internalized real and ideal images of self as womanly mother. Rubin reflected this process as volitional; therefore not every young woman would experience this dimension of personality. The phenomena was more than sentiment: "There is a belonging as a part to the whole personality, bound-in and inseparable, a maternal identity" (Rubin, p. 38). Rubin stated that the reality of maternal identity was replicated with each childbearing experience as a new experience.

According to Rubin, each pregnancy was perceived within contextual newness, and each pregnancy required maternal tasks to be completed. Progression in the development of maternal identity was through replication of models, essays of role playing, exploration in fantasy of the nature of the child and her experience with it, loosening established bonded relationships to accommodate a new relationship, and

differentiating self from models.

At the beginning of pregnancy, early in labor, and early postpartum period, Rubin observed a direct, literal copying of practices and customs of other women in the same situation, women who have successfully met challenges, or the recommendation of experts. The expectant mother relied and used her own mother's example to serve as a guidepost for her own behavior.

Internalization of the maternal role also occurred through fantasy, or projection in imagery of mother and her child into the future. Most of the early fantasies of the expectant mother were of the child, and Rubin found that regardless of their own coloring, many mothers visualized a blonde, light complexioned child, about six months in size, a cherub. The expectant mother may in fantasy dress or feed the child, and the mother visualized an idyllic situation. Fantasies changed as pregnancy progressed, near term fantasies were fear-fantasies of the delivery experience. These fantasies also included images of the woman returning to sports, being thin and trim, engaged in social activities, and having more energy and time to devote to herself. Fantasies also included death, as the expectant woman in the third trimester cleaned the house so that all was in "dying order", or conversely, ready for a welcome guest. The mother may write a will, and if she had other children she arranged for their care. Some degree of

distancing from relationships commonly occurred as the woman prepared for a new relationship and a new person, an aspect of the dedifferentiation process described by Rubin. This process was characterized by development of a maternal identity from which the expectant mother examined and experienced motherhood.

Maternal tasks.

"Childbearing requires an exchange of a known self in a known world for an unknown self in an unknown world" (Rubin, 1984, p.52). In exchanging known for unknown, the woman had two primary foci; conserving herself and her family as progressive, open systems, and managing the assimilation of the new child into the self and family system. These activities took place through examination and work on existing relationships in order to make room the new child within the family. Rubin identified these activities as tasks of seeking safe passage, seeking acceptance by others, binding-in to the child, and giving of oneself. Tasks took place through replication (of maternal roles), fantasy, disengagement, and differentiation.

One primary maternal task salient in the issue of women and drug use was the seeking of safe passage as Rubin described. The first trimester presented an event, amenorrhea, as the only indication of pregnancy. As the pregnancy progressed into the second trimester other bodily

changes occurred, leading to experiential knowledge that a baby was carried within the woman's body. This experience prompted the woman to seek prenatal care as she thought about having a healthy baby. The third trimester brought about concern for the baby and the self as labor and delivery issues were inseparably important to both infant and mother.

Seeking safe passage was accomplished in several methods. The mother "information loads" (Rubin, p. 55), reading and data gathering in a variety of ways about childbearing and mothering. "There is an intense, and extensive review of the literature in order to take preventive or avoidance measures to ensure safe pregnancy" (Rubin, p. 55). Knowledge about pregnancy gathered from reading was enlarged by eliciting accounts from other women who experienced pregnancy and delivery. This point raises questions about mothers who are using drugs, their sources of information, and behaviors regarding drug use, questions which will be pursued within this study.

Rubin observed that information gathering was anxiety provoking, and that pregnant women self-regulated anxiety by ceasing their data gathering to modulate their anxiety at tolerable levels. The sense of personal danger was heightened at the seventh month when the pregnancy became a physical hardship. The fetus was bigger and more vigorous, and stretch marks and loss of balance become common

experiences. Rubin also observed that women increased protective measures at this time such as putting additional locks on doors, acute listening for threatening sounds, caution in driving or ceasing to drive, and avoiding being alone. Irritability or emotional lability resulted from lack of sleep and was frequently reported.

Another maternal task was to seek acceptance by others, an example of social aspects of pregnancy and motherhood. The husband or significant other was a key figure, contributing support and bolstering confidence and self esteem of the pregnant woman. Teenage mothers worked for acceptance from their parents, attempting to gain approval as daughters, not mothers. In these instances, formation of maternal identity was stalled by the need for parental acceptance. The single woman was in a unique position of potential social solitude during pregnancy and childbearing. "As long as she hopes that the partner in conception can or will accept the child, the woman pursues all maternal tasks" (Rubin, p. 60).

Everything, stated Rubin, done or not done in behalf of a yet unborn and unknown child was in the abstract concept of a child and relationship to the child. If a mother is drug using and absorbed in her social and self sphere, can she abstract a reality of an unborn child? Are her social relationships sturdy enough to support the woman during Rubin's description of maternal tasks? As Rubin notes,

letting go of gratifying pleasures is always difficult, especially if required to satisfy an abstraction.

The task of binding-in to the child occurred despite discomfort and body-self deprivations that occur during pregnancy;

The experience of pregnancy is an experience of the self, conceptually quite separable from the childbearing experience. In pregnancy there is a taking-over of the woman's body, its boundaries, functions, appearance, and intactness. The idea of pregnancy in its consummatory relentlessness is not easy to accept. Pregnancy is temporary, but it lasts 'too long', goes 'too far', and there is no guaranteed return of the usurped body. The cost of pregnancy is inordinately high and the benefit is moot. It is the tipping of the balance in favor of the benefits that a woman binds-in to the pregnancy to sustain, endure, and accommodate to term and through labor. (Rubin, p. 63)

As the pregnancy continued, the fetus became sensorially available to the woman and she ascribed characteristics to it depending on its behavior. For example, she was aware that the baby turned, kicked, spread its fingers, and rested. Increasing awareness of the baby and its habits provided a series of behaviors the mother identified and recognized as her own child's. The hidden nature of the child, and the intimate and exclusive nature of the relationship between mother and unborn baby, all provided the foundation for the emotional binding-in process that Rubin described. When the baby was born, it is known and then becomes manifest.

The fourth maternal task, giving of oneself, occurred both personally within relationships and in a larger social

context. On an individual level, the gifts of food and clothing the woman received during pregnancy represented appreciation for the contribution she was making to society through childbirth, and represented personal caring of others close to her. Rubin referred to gifts and caring as narcissistic pleasures of pregnancy which if satisfied, extend and transfer to the newborn upon delivery. Extension and transfer occurred as the mother took pleasure in the baby's appearance, good health, thriving, and attainments. Compliments and gifts to the child were experienced by the woman as gifts to herself. Gift giving through pregnancy is reciprocal. Sacrifice of self as her body changed and willingness to endure dangers of childbirth constituted gifts at a personal level. Gifts extended to the society through awareness of her contribution through providing children in sustaining culture and society.

Critique of Rubin's framework.

Rubin's description of childbearing is a middle class idealized image of the childbearing phenomena in Western culture. She discussed her findings, discovered through naturalistic research, of experiences of pregnant women situated in a traditional family. Although acknowledging that childbearing occurred in a sociocultural context, she did not comment on the larger socially constructed reality in which childbearing takes place. While consideration of

larger cultural issues was not her purpose, and she made no judgment about culturally determined behavior, she presented an incomplete picture of childbearing phenomena (Kay, 1982). Significant others were accorded little explicit importance other than providing material and symbolic support to the pregnant woman. Implicitly, significant others co-created the social reality in which the experience of pregnancy exists. Provision of material and symbolic support represented significant controls of the environment in which reproduction occurs.

Feminist Views on Childbearing

Other scholars investigated motherhood within cultural and social frameworks. Feminist scholars generally agreed there was nothing preprogrammed or prepackaged in maternal behavior (Oakley, 1979; Rossio, 1987; Chodorow, 1979). They argued that maternal behavior was learned and not instinctual (Chodorow, 1979; Eichenbaum & Orbach, 1989), and considered childbearing embedded in a Western patriarchal social context (Firestone, 1970). Feminist scholars primarily emphasized 4 interrelated psychological themes relevant to mothering; blaming and idealizing the mother, extreme expectations of maternal sexuality, a link between motherhood aggression or death, and an emphasis on the isolation of mother and child. "All these themes share common characteristics: their continuity with dominant

cultural understandings of mothering and their rootedness in unprocessed, infantile fantasies about mothers (Chodorow & Contratto, 1982).

Good mothering, it is said, is an ideological construct and we are warned that blame and idealization of mothers have become cultural ideology. "Belief in the all-powerful mother spawns a recurrent tendency to blame the mother on the one hand, and a fantasy of maternal perfectibility on the other (Chodorow & Contratto, 1982, p. 55). Chodorow (1978, 1987) writing from a psychoanalytic framework, approached the phenomena of mothering using object relations theory. She questioned Freud's original thinking about childbearing and identified mothering identity and behavior as passed on from mother to daughter. Mothering occurred through social structurally induced psychological processes. "It is neither a product of biology nor of intentional role-training" (Chodorow, 1978, p. 7). Questioning the need for all essential parenting to emanate from the mother role, Chodorow included the role of both parents in her writing.

Biological (Firestone, 1970; Rossio, 1987), or sex-role socialization theories (Oakley, 1979) were also posited to explore mothering behavior and childbearing issues. These writers explored the belief that reproductive differences between the sexes, namely childbearing, lead to a sexual division of labor that fostered women's oppression by men. According to Firestone (1970), the only way to expunge

sexual domination was to relieve women of childbearing. This technological feat would curtail both biological and social motherhood, freeing women to be individuals liberated from sexual repression. Rich (1976) conversely felt that motherhood was an essential experience for women. She called for a "repossession" of women's bodies and claimed that the essence of motherhood was distorted by patriarchal society.

The potential for destruction was related to mothering as women face possible death during childbirth. Also, underpinnings of aggression and death were identified in the social role of mothers in Western society (Chodorow & Contratto, 1982);

If having a child makes a mother all-powerful or totally powerless, if women's maternal potential requires the desexing of women or enables fully embodied power, then the child who evokes this arrangement must also be all-powerful. The child's existence or potential existence can dominate the mother's. (p. 60)

A cyclic process of aggression stemmed from women's experience of motherhood in Western society. Anger emanated from women's role in a patriarchal society and flowed from mother to child, from child to mother, from mother-as-child to her own mother. "Cemented by maternal and infantile rage, motherhood becomes linked to destruction and death (Chodorow & Contratto, 1982, p. 60). Rich (1976) viewed the continuity of violence differently; from men to women and from women to children. More current writing

(Carter, 1992; Napier, 1991; Pittman, 1991) postulated the role of the father in family dynamics. The traditional Western role of the father contributed to a cycle of emotional estrangement within the family;

The male who doesn't know his father - and thus doesn't know how to parent - and fears emotional control by women, becomes a distancing figure during the early childhood years of his own family; and when he withdraws in fear and anxiety, his wife turns to her children for support; and the cycle begins again (Napier, 1991, p. 13).

Women's anger contributed to the impetus of the cycle of estrangement;

...this has been an unjust system for women; the tremendous emotional burden of children's needs, the social isolation, the lack of support from the children's father, the low status, the absence of overt power, the lack of intellectual satisfaction. As women have taken jobs and pursued careers outside the family, this situation has in certain respects become more unjust, not less; since women today have kept many of their old responsibilities, and simply added new ones. (Napier, 1991, p.12).

Psychological isolation of the mother and child is described by Chodorow and Contratto (1982); "Mother and child are on a psychological desert island" (p. 63). Either the mother and child dyad is seen as perfect and complete as in the romantic view of motherhood, or the dyad is seen as isolated from society and static.

Bergum (1989), posited that the experience of motherhood was complex, internal, and psychologically transformational;

Being a mother is a matter not only of the mother role, not only of caring for the child, not only of caring for a home. It is a matter of a changed

understanding of who women are as mothers. Becoming a mother is a matter not only of maternal tasks, not only of developmental tasks, not only of stressors and satisfactions. It is a realization and acceptance that 'I am a mother.' (p.150)

Motherhood is an integrated inner and outer experience, an transforming important life event, experienced uniquely and within the contextual complexity of each woman's life.

Summary, Literature Review

Women who use drugs while they are pregnant experience both the phenomena of pregnancy and substance abuse. The question is clear: How do women experience dual realities of substance abuse and pregnancy? Review of the literature presented inquiry about substance abuse and women focused on addiction or pregnancy outcomes. Psychological information exists that explores mothering in Western society. Studies have not been located that describe the experience of the woman using drugs while pregnant. Profound lack of information prompts questions about the phenomena.

Despite many approaches to substance abuse and to pregnancy, no research has been discovered that describes or explains the experience of pregnant women using drugs. When mentioned in the literature on substance abuse, pregnancy is cited as an event in the life of a drug user but is not explored in depth. When mentioned in the literature on pregnancy, substance abuse is mentioned as a behavior to be avoided or curtailed. Neither approach addresses the

importance of combined phenomena nor acknowledges importance of both experiences. Privately, therapists say that some drug-using women quit using drugs while they are pregnant, resuming use once the baby is born. However, increasing numbers of exposed infants in hospitals make an opposite statement. What prompts or permits some women to abstain from using drugs while they are pregnant? When do they find out they are pregnant?

Since theory about substance abuse was formulated using men as subjects, women's experience has been unexplored and has surfaced primarily in codependency literature. Descriptions of behavior labeled as codependent describe women's roles prescribed by this society.

Theories of pregnancy developed from women's experience and framed in sociocultural contexts are often addressed in the literature. Combined influences of substance abuse and pregnancy present intriguing and complex intersecting situational phenomena. Since the issue of substance use and pregnancy is such a societal concern, it is difficult to understand why this area has not been more fully researched. Thus, there is a need to explore these issues, a need this research addresses.

CHAPTER THREE

METHODOLOGY

The purpose of this study and the exploratory nature of the research questions supported use of qualitative methodology as an appropriate approach to inquiry. Many qualitative methods exist, and among them the phenomenological method was appropriate to this study because the method uniquely contacts the individual's experience of a given phenomena. In this case, the phenomena were women's experiences of being pregnant and being a substance abuser.

Of the qualitative methodologies, phenomenology seeks to uncover the meaning of human experience through analysis of the subject's perception by description (Parse, Coyne, & Smith, 1985) of experiential phenomena. Phenomenology, like other qualitative methods, captures the process of interpretation of events (Bogdan & Taylor, 1984). The "capture" process is grounded in the philosophic principle of the primacy of perception (Valle & King, 1978). Perception constitutes meaning of experience of events or phenomena, contacted by the phenomenological method.

Perception of, or consciousness of (Natanson, 1967)

meaning or being in the moment is central to phenomenological philosophy. There is no objective reality to the phenomenologist (Smith, 1989), nothing exists in itself independent of its interaction with a perceiving meaning-giving being (Merleau-Ponty, 1974). While acknowledging physical reality, phenomenologists believe the mind is the creator of knowledge (Filsted, 1979), and that meaning of the world emerges and results from a relationship between a sentient being and the world (Smith, 1989; Van Manen, 1990). Reality cannot be known separate from a person's experience and interpretation.

Phenomenology focuses generally on the daily lives of people, and on their experiences of living and being in the world (Munhall & Oiler, 1986) as opposed to measuring preconceived ideas about phenomena. Phenomenology specifically asks the question, "What is it that makes the lived experience what it is" (Van Manen, 1990, p.32). In the process of contacting experience, the researcher "...allows what we see to teach to comprehend the seen as opposed to forcing our comprehension of the seen to determine our seeing" (Valle & King, 1978, p. 67). In other words, the researcher does not suppose objectivity. The researcher examines existing bias and accounts for them in the research method, as will be seen. The researcher facilitates discovery through qualitative research processes and techniques as phenomena emerges, discovers, and describes

its own character and features. A phenomenological concern, says Van Manen (1990) has a twofold character, a preoccupation with the concreteness (the ontic), as well as the essential nature (the ontological) of a lived experience. "Phenomenology is not concerned primarily with the nomological or factual aspects of some state of affairs; rather, it always asks, what is the nature of the phenomenon as meaningfully experienced" (p.40). The point of phenomenological research, says Van Manen (1990) is to "construct a possible interpretation of the nature of a certain experience" (p. 41).

Traditions of feminist inquiry also guided this research. Bernhard (1984) identified criteria she used to review research to determine if they embodied feminist methods. Among the criteria were; interaction between the researcher and the subject, expression of feelings, and concern for values. Further, the study had the potential to help the subjects as well as the researchers, and the research was focused on the experience of women subjects. Additionally, the purpose of the investigation was to study women and the word "feminism" or "feminist" was used in the research.

Although a feminist study is not limited to inquiry related to women, the attributes of feminist inquiry as presented apply to this research. Interchange between researcher and participant is suggested in feminist

criteria. Correspondingly, Van Manen (1990) says of phenomenology,

Some argue that phenomenology has no practical value because 'you cannot do anything with phenomenological knowledge.' From the point of view of instrumental reason it may be quite true to say that we cannot do anything with phenomenological knowledge. But to paraphrase Heidegger, the more important question is not: Can we do something with phenomenology? Rather we should wonder: Can phenomenology, if we concern ourselves deeply with it, do something with us? (p. 45).

Feminist research and phenomenology therefore involve an attitude of dynamic openness to the question at hand, experiencing an "abiding concern" that made the question possible in the first place.

The focus of inquiry for this study was the experience of pregnant women who have used drugs while pregnant. Research exists to delineate birth outcomes of drug exposed infants and difficulties of labor and delivery, however, information about the experience of pregnant women is limited. When phenomena under study are unexplored, Lincoln and Guba (1985) recommend a naturalistic, or qualitative, approach to the phenomena. Using this approach, the lived experience is explored (Munhall & Oiler, 1986). Exploring the lived experience reveals what is in the consciousness of the individual (Natanson, 1967). Consciousness, according to phenomenologists, occurs as consciousness "of" something. The discovery through phenomenologic methods of what one is conscious of produces description of the meaning of being in the moment or the experience (Natanson, 1967). Experience

is subjective, objective, and contextual (Valle & King, 1978), aspects of "being-in-the-world (Swanson-Kauffman & Schonwald, 1988) approached through phenomenological methodology. As layers of meaning which provide interpreted experience, what remains is the perceived world (Oiler, 1986). The perceived world creates the reality in which intentional acts are performed.

Phenomenology is not easy to describe because it is a fluid approach to discovery and has been variously described as a philosophy, method, and approach to phenomena (Psathas, 1973). Referring to the evolutionary nature of phenomenology, Swanson-Kauffman & Schonwald (1988, p. 97) state that phenomenology deals with "...concession, compromise, and approximation". Various philosophical interpretations are described by researchers (Colaizzi, 1978; Giorgi, 1970; Spiegelberg, 1965, 1982; Van Manen, 1990) who use different processes to analyze data. Unlike positivist science, phenomenology by its nature is ever evolving, nonetheless, different schools agree on essential methods of inquiry (Spiegelberg, 1965, 1982).

Three progressive, though not linear, research processes reflect the essential method of phenomenology generally agreed upon by various researchers (Colaizzi, 1978; Giorgi, 1970; Spiegelberg, 1982; Van Manen, 1990). The first is the investigation of phenomena, the second is investigating general themes (or essences) of the phenomena,

and the third is apprehending essential relationships among themes. A synthesis of Spiegleberg's (1982) and Van Manen's (1990) processes of phenomenological inquiry was used in this study.

Spiegleberg's Method of Phenomenology

Step 1: Investigation of the Phenomena

Investigation of the phenomena was the first step in Spiegleberg's (1982) model. Three interrelated, not necessarily linear, operations form this step. The first operation was intuiting, which required complete absorption into the phenomena at hand "...to the point of no longer looking critically" (Spiegleberg, 1982, p. 682).

The second operation was phenomenological analyzing in which the elements of the phenomena were traced and the structure of the phenomena was obtained by the first intuitive process. "It comprises the distinguishing of the constituents of the phenomena as well as the exploration of their relations to and connections with adjacent phenomena" (Spiegleberg, 1982, p. 691).

The third phase was phenomenological describing, based on the researcher's progression through the first two steps. "Phenomenology begins in silence", said Spiegleberg (1982, p. 693), as the researcher struggled to articulate the puzzle of meaning. An analogy is a person examining a map and finding coordinates of a very general area within a

larger one, a city within a state, for example. The researcher at this point locates general, not specific coordinates of the phenomena. The context is considered, may or may not be familiar, the questions are posed, and the researcher is ready to continue analysis of emerging data to discover other relationships.

Van Manen (1990) suggested the researcher "orient" to the phenomena and identify one's vantage point. An educator would approach phenomena differently than a lawyer or a nurse. Becoming familiar with the concrete (ontic) phenomena one was interested in as well as the essential nature (ontological) of the event was recommended.

Step 2: Investigating General Essences

The second step is eidetic intuiting, or investigating general essences. An essence (or Theme, according to Van Manen, 1990) described those parts of an experience which represented essential features and represented common patterns of the phenomena. The intuiting of particular parts of the phenomena led the researcher to arrive at essences, features without which the phenomena would not be what it is (Psathas, 1973). For example, a rose may be considered for its particular shade of pink. The rose may come to exemplify pinkness, and further to represent (the essence or theme of) color. Thus, the intuiting of particular features provided a pathway for apprehension of essences. "...on the basis of seeing particulars in their structural affinities we also become aware of the ground of their affinities, the pattern or essence" (Spiegelberg, 1982, p. 698). Arriving at essences describes the "whatness" of the phenomena.

Step 3: Apprehending Essential Relationships

The third step was apprehending essential relationships. To apprehend essential relationships, one apprehended internal relationships between, say the pink flowers, and the external relationship of other essences, or other properties of flowers. Apprehending relationships is a result of imaginative variation, or substituting some

features to see if substitution resulted in changing essences. For example, removing color from the pink rose would profoundly alter the essence of a flower, changing it's "whatness."

Step 4: Watching Modes of Appearing

The fourth step was watching modes of appearing. Spiegleberg (1982) described watching the way in which phenomena appeared, not just what appeared. One considered the "givenness" as the whole, the aspect that first appeared or was slanted toward the observer, and the indistinct aspect of the object or phenomena. What appears first? What was most remarkable about the appearance? What about the phenomena remained fuzzy, peripheral?

Step 5: Exploring the Constitution of Phenomena in Consciousness

The fifth step is exploring the constitution of phenomena in consciousness. This step lies in determining the way phenomenon establishes itself and takes shape within our knowing, our consciousness. Spiegleberg (1982) offers the metaphor of arriving in a new city and learning about the geography of the city. Knowledge is gradually constituted and developed, one becomes familiar with key features of the city and other "background" information which characterize the city. The metaphor is carried

further by suggesting that knowledge of the city (phenomena) takes place after experiencing disorientation, making false starts, and being lost.

Step 6: Suspending Belief in Existence

The sixth step is suspending belief in existence. Included in this step is Husserl's "bracketing" function as described by Spiegleberg (1982). In this process, one considers all data as equal, even if bias exists for or against particular data. All data, real and unreal, or doubtful, are investigated "...without fear or favor..." (Spiegleberg, 1982, p. 710).

Step 7: Interpreting Concealed Meanings

The seventh step is interpreting concealed meanings, a step which Spiegleberg added to embrace evolutionary philosophical thought. The interpreter of data goes beyond what is immediately given on the surface to elicit hidden meaning which may be beyond intuiting, analyzing, and describing. Interpreting concealed meanings takes place by extending intuitive analysis beyond what is apparent and is described as "...intuitive verification of anticipations about the less accessible layers of the phenomena, layers which can be uncovered, although they are not immediately manifest" (Spiegleberg, 1982, p. 713). Anticipating criticism for this component of the method, Spiegleberg

approached it cautiously. He warned the researcher to avoid empirical hypotheses which phenomenology works to avoid. This step extends phenomenology beyond description and enriches understanding by uncovering meaning.

Development of Thematic Identification Van Manen's Method

Themes and essences were different terms for the same designation of phenomena, according to Van Manen (1990). A theme described an aspect of the structure of the lived experience. Themes articulated in phenomenologic research constituted the structure of lived experience, according to Van Manen (1990). Four aspects of themes were discussed. Themes were the experience of focus, of meaning of the point. Further, theme formulation was a simplification. "We come up with a theme formulation but immediately feel that it somehow falls short, that it is an inadequate summary of the notion" (p.87). Themes were described as intransitive verbs, the objects always evolving and changing. The point that phenomena are always in dynamic change and never static was reflected in Haraway's (1988) observation of feminist research, "Feminist objectivity resists simplification in the last instance" (p.590).

Articulating themes was the practice of the phenomenologist and came about for 4 reasons, says Van Manen (1990). Expression of theme was both the desire to make sense and the sense we are able to make of a certain

situation. Theme was the openness to something, arrived at by opening self to a lived experience. Theme was the process of "insightful invention, discovery, and disclosure" (p.88).

Themes related to the phenomenon being studied in several ways. Themes were the tools the phenomenologist had to approach the experience, and give shape to the shapeless. Themes described the content of the phenomenon, but were always reductions. "No thematic formulation can completely unlock the deep meaning, the full mystery, the enigmatic aspects of the experiential meaning of a notion" (p.88).

This research utilized Van Manen's nomenclature and represent the structure of the experience utilizing major and minor themes.

Specific Research Strategies

Sample

The participants of this study were women 18 and over who used drugs while they were pregnant. Average age of participants was 34. The group included women of caucasian, hispanic, African-American, and Asian and African-American descent. All participants were active members of recovery groups. A brief description of each woman is included in Appendix A.

The recovery groups were located in a formal, licensed

entity utilized by the county as a referral agency for this population. Most women presented to this agency as referrals from other community sources or as a court mandated activity. Participants fulfilled Colaizzi's (1978) criteria for selection by having lived the experience, and were able to discuss it.

Sample size for this type of study was addressed by Lincoln and Guba (1985), who recommend a sample size sufficient to meet the point of "diminishing returns" (p. 234), the point at which information becomes redundant. Taylor and Bogdan (1975) provided similar guidelines, stating that the beginning researcher include 8 to 25 subjects in order to achieve proficiency with a relatively small sample size. Both sources speak to typical feelings of the researcher in that the data never seems complete, but that when no new insights are gained, or theoretical saturation (Glaser & Strauss, 1967) achieved, the sample has been adequate. Sample size for this study was accordingly estimated to be between 9 and 11 participants. Eleven women volunteered to participate in this research, all but one were interviewed twice. One participant interviewed once was dismissed from the program before the second interview was accomplished.

Data Collection

I approached potential participants at the location of their recovery program, speaking either during group meetings, or to program members individually. During groups, I explained the nature and purpose of the study and invited participation. I also shared varieties of experiences as a nurse working in different settings with patients who had difficulties with substance abuse. Sharing personal and professional information put the group more at ease and supported an immediate rapport.

The consent form was distributed to all the members of the group explaining the study and listing the researcher's phone number in the event participants wished to contact the researcher confidentially. As a group, we read through the information/consent form and those wishing to participate signed the consent and gave it to me. Others kept the form with my home number in the event they decided to contact me personally. This did not occur, and all but two participants volunteered during the groups. I was surprised at the readiness of volunteers, and pleased that so many volunteered during the groups. Two others became interested in the study by hearing about it from other participants or by hearing about the study through their counsellor. These two participants and I read through the information/consent form at the beginning of the interview and we clarified any

questions. They then signed the consent before the interviewing began.

A common theme expressed by the participants was the wish to help others in the same situation. They felt that participating in the study could help others. Two groups asked me if I was going to write a book, and jokingly if I were going to be on "Oprah". Despite negative replies about television appearances, they continued to volunteer.

Participants who expressed interest in joining the study agreed to be interviewed twice for a total time of approximately four hours, and agreed to tape recorded interviews. All of the participants who volunteered during groups gave me their phone numbers and agreed that I could contact them at their residences. Most expressed an preference for being interviewed at the program location. Seven interviews of the total twenty one interviews were completed in other locations; five in participant's homes, two in my car parked near the schools of two other participants. Many of the interviews done at the program location were accomplished in my vehicle since there were no rooms available at the program. Participants enjoyed sitting outside in the car, talking. The informality of the setting put them at ease.

Interview Process

Each participant was interviewed twice with the exception of one participant who was dismissed from the program before the second interview was accomplished. Material from the first interview is included in findings. Well in advance of interviews, I called the participants to remind them of our appointments. Only a few participants failed to come to appointments, and always came the next time we arranged to meet.

Each interview was tape recorded and promptly transcribed by the researcher onto computerized word processing discs. The researcher reviewed each transcript and added narrative, nonverbal, or other contextual information to the text of the interview in order to capture details which might not be represented adequately in the text, and to capture nonverbal material.

In the interim before the second interview which took place at a mutually convenient time about one to three weeks later, I reviewed pertinent data gathered from the first interview, made notes of information that was unclear or that I wanted to validate with the participant. The interval between conversations allowed time for the participant to reflect on the data, and to think of additional information (Omery, 1985). During the interval I reviewed initial data to identify emerging features, themes, and patterns of emerging data.

The interviews were unstructured. Representative sample questions are located in Appendix B. The researcher assumed a flexible style, encouraged the subject to speak in their own voice about the topic (Lofland & Lofland, 1984), and to speak about their thoughts, feelings, and perceptions of the experience. The interview began with an open statement to encourage the participant to speak about their experiences with the phenomena. As a result of participants' involvement in 12 step programs, they would frequently begin the interview as if they were in an Alcoholics or Narcotics Anonymous meeting, "My name is, I'm 34 years old and my drugs of abuse are alcohol and cocaine. I've been using drugs and alcohol since I was 15 and I'm here because I got into trouble with drugs after I had a baby and I needed to get into a program." This type of introduction was a comfortable affirmation for them, and provided an excellent entree into questions I was curious about. Typically they would make very brief eye contact during that kind of introduction. I asked one participant what prompted her to look down when she initially spoke and she said although she had not noticed it, she believed it was due to customarily sharing information with a group. It was difficult for her to make eye contact with many people at one time. The interview continued until both parties felt that the phenomena was fully explored, or until the participant needed to terminate the interview for scheduling

purposes.

Bracketing

Assumptions about phenomena which comprise preunderstanding (Natanson, 1973) of the phenomena were cognitively withheld from consideration during the research process. This process allowed me to theoretically confront the phenomenon without contamination from previous ideas (Natanson, 1973), and allowed phenomena to emerge without my prior ideas imposed on the emerging data (Rose, 1990). Assumptions have been listed in Chapter One.

Ethical Considerations

This proposal was submitted to the Committee for the Protection of Human Subjects at the University of San Diego before data collection began and the study was conducted under the aegis of, and according to the guidelines of the Human Subjects Committee. Approval of the committee can be found in Appendix D.

Participants were informed of the purpose of the study and were informed of the methods of maintaining their anonymity and confidentiality during and after the study. The researcher and the participant reviewed the consent form verbally and the participant was encouraged to clarify any questions about the study at that time. All data was coded and names were removed when the transcripts of the interview

were printed. Tapes will be destroyed when they have been reviewed and the material has been accepted. Names of participants were known only to the researcher, and the list will be destroyed at the end of the study. All interview materials were kept in a locked file inaccessible to all but the researcher.

Prior to collecting data, one potential circumstance was identified that may have caused the researcher to breach confidentiality, the State of California's requirement for professional persons to report suspected or real instances of child abuse. I also felt a moral obligation to report this event. If a study participant related current abusive events, I would report these instances to the State of California Child Protective Services. This contingency was noted in the information/consent form and was verbally explained to each potential participant. Participants were comfortable with the situation, and no circumstance during the study evoked this provision.

Risks

It was not anticipated that participants would be at risk as a result of involvement in this study. It was possible that speaking about the phenomena would raise participant anxiety. The concurrent active involvement of the subjects in recovery group activities supported their ability to deal with anxiety regarding an issue they were

currently addressing. As a routine service, the recovery groups provided additional individual counselling should participants request adjunct support. If, however, the participants requested further support, a psychotherapist paid by the researcher was available to see a participant within twenty four hours of their expressed need. This contingency was included in the consent form and discussed during the first interview. No instances arose which necessitated engagement of this therapist. Participants generally agreed that it felt good to talk about their experiences.

Consent

Interested potential participants received an information letter combined with a consent form which they reviewed. Information about the study was reiterated at the beginning of the first interview before data collection. Ample opportunity existed for questions and/or clarification of issues. Participants were free to ask questions at any time during the study, and were free to withdraw from the study at any time.

Anonymity and Confidentiality

Protection from exposure of personal material was achieved through methods to insure anonymity and confidentiality. All data was coded to eliminate any names

mentioned during interviewing. During the writing phase of the research, names of participants were fabricated to protect identity. Possible publications resulting from this study will use pseudonyms, and data would be reported in such a way that individuals could not be identified. All taped materials will be destroyed after the study is accepted, and the researcher had exclusive access to materials during the study. The researcher retains transcribed data for future reference.

Data Analysis

Data analysis was conducted using a combination of the methods of Colaizzi (1978), Spiegleberg (1982), and Van Manen (1990). A non-linear, continual analysis is an essential feature of the phenomenological method. Writing is the (phenomenological) method, says Van Manen (1990), research does not merely involve writing, it is the writing. "The methodology of phenomenology requires a dialectical going back and forth among various levels of questioning" (Van Manen, p.131). I found myself in continual dialogue with the material, going between parts and whole in order to represent experience. I utilized personal journal entries to recapture feelings I had during and after conversations with participants. I wrote and re-wrote, beginning with highlighting sentences from interviews. From these statements, major and minor conceptual "themes" emerged and

many revisions ensued.

Outside readers were used as Spiegleberg (1982) suggested, to support the researcher in extracting significant essences and themes from the data. One nurse therapist working in substance abuse treatment, one nurse therapist interested in women's issues, and one nurse midwife each reviewed three transcripts to gain an understanding of the process of the interviews and themes elicited from the interviews. Transcripts were from women new to recovery, midway through recovery, and nearing completion of the recovery program. The reviewers then read at least one draft of Chapter 5 to ascertain if the themes and personalities from the interviews appeared. Review was helpful and gave me several additional insights relative to the process of pregnancy. Themes of recovery were identified by a nurse therapist and applied to the findings.

Field notes were utilized to note any remarkable material about the interview either during or after the interview. I made notes after each interview which I compiled into a journal format. Sometimes I talked into the tape recorder in the car on the way home, reflecting my impressions of the conversation. Feelings and impressions from the interviews were helpful to reflect on and provided a fuller sense of the reality for the individual participant, and for me.

The following nine steps were utilized for data

analysis:

1. I transcribed each audiotape verbatim onto a word-processing disc.

2. Each audiotape was reviewed and initial nonverbal and/or other contextual information added using word processing technology.

3. Audiotapes were listened to at least twice to further familiarize myself with the contextual density and features of the phenomenon.

4. I reflected on each tape and/or transcript numerous times in order to more fully appreciate the data. Patterns of emerging themes were noted.

5. I reviewed the written transcripts of participants and major and minor themes identified.

6. Each transcript was reviewed in this manner, and compared with other transcripts.

7. Themes were identified both within individual experiences and in common with other experiences.

8. During the second interview, participants validated and/or clarified data obtained during the first interview. Data obtained from the first interview may have been reviewed with the participants for meanings of significant statements and thematic descriptions.

9. A statement of the formulated structure of experience of women abusing drugs while pregnant was written from the description of major and minor themes.

As stated, the process of intuiting, analyzing, and describing continued through each step of the analytical process. Spiegleberg's steps as described were employed as analysis of the data proceeds, and Van Manen's (1990) method incorporated. Rose (1990, p. 61) described an "...unrelenting dialectical encounter between the researcher and the data...", an encounter the researcher anticipated and but only fully appreciated during the present study. Transcriptions were reviewed and amended for contextual accuracy as described, and using Colaizzi's suggestion, reviewed many times to gain a sense of the whole (Colaizzi, 1978), and to retain the essence of the person speaking.

Moustakas (1990) is critical of phenomenology because he believes that "detachment" of researcher from phenomena occurs, that the researcher "loses" the person in the process of descriptive analysis. I attempted to give voice to the emotional reality of the dialogues in order to fairly represent participants. Actual names were omitted from typed transcripts to ensure participant anonymity.

Journaling/Researcher Process

I became interested in women who use drugs during pregnancy while I was employed in a high volume women's center where the majority of patients came from insured families of middle incomes. Society's presumption that prenatal substance abuse occurred in low socioeconomic

groups was refuted by my experience. I witnessed many painful scenes of mothers leaving their infants to foster care because of a positive drug screen, and saw many infants in various stages of drug withdrawal. I counselled the staff after one father removed his heroin exposed infant from the nursery illegally. Why, I asked myself, would a woman continue to use drugs during pregnancy? I had a great deal of exposure to substance abuse during years of nursing, and I witnessed the power of addiction. But something was different about this situation beyond addiction. What were women thinking about? What were their choices? What informed them?

The incidence of drug related problems seemed to be inversely proportional to the denial among some staff and medical personnel. Mothers who were found to have positive toxicology screens were perplexing to staff who didn't know how to speak to them. Staff struggled with their own feelings about "their" patients using drugs while pregnant. Staff's own feelings sometimes prevented them from engaging in a professional relationship with the patient.

Thus, I found myself interested in the situation that supports drug use while pregnant. My initial thought was to conduct a qualitative exploration using grounded theory methodology. Time constraints preclude this approach and I consider this study to be preliminary to a later grounded theory endeavor.

In collaboration with my advisors, I decided to keep a journal of my own thoughts, feelings, and processes while I investigated the phenomena with participants. Doing so allowed me to track my own process, become aware of countertransference issues, and kept me on track as a researcher. I considered my experience in psychosocial nursing a distinct advantage in conversing with participants. I also considered it a hazard because assuming a therapeutic role was natural and clearly inappropriate. Identifying pitfalls may aid future researchers avoid problems. One advisor was expert in therapeutic interventions and provided feedback as needed. I met with her twice during data collection to validate both my interview methods and feelings about the participants and the phenomena under study.

Methodological Rigor

Qualitative methods have become more frequently used among nurse researchers, and Burns (1988) suggested adopting generally accepted criteria in order to evaluate reports. Incorporating principles of methodological rigor into studies provides readers and researchers evidence that findings are acceptable. Qualitative methodology must be approached with different assumptions and standards than quantitative research (Burns, 1988; Lincoln & Guba, 1987; Cobb & Hagemaster; 1987; Sandelowski, 1986).

Lincoln and Guba (1987) presented four criteria appropriate to application of qualitative rigor. The first criteria was "truth value" (p. 296), or credibility of the study. Credibility was similar to reliability in quantitative studies, and was established in that findings of the study were true to persons experiencing the reality represented in the study. In this study, data gathered from the first interview was shared with participants in order to verify that I accurately represented their realities during data collection.

The second criteria was applicability or transferability (Lincoln & Guba, 1987). The results of qualitative research apply to the participants of the study, rendering extrapolation of the findings to other populations questionable. Although Cobb and Hagemaster (1987) felt that it was the responsibility of the qualitative researcher to make their work understandable to the "dominant culture" (p. 139), Lincoln and Guba (1987) felt that applicability of findings did not lie with the qualitative researcher but with others who seek such generalizations. Representing the research in adequate detail allowed others to judge the merits of the study and the applicability of findings to other studies.

Consistency or dependability was the third criterion (Lincoln & Guba, 1987). This standard was similar to validity concepts in quantitative research, and required

demonstration of methods to ensure the study examined phenomena as stated. Acknowledging content and process of dependability, I responded to emerging data and shifted the process of research in order to capture pertinent information. For example, new questions were asked of participants as themes emerged. Recording the methodological process reflected consistency of the method. Further, bracketing, a methodological step in phenomenology (Oiler, 1986), provided acknowledgement of my efforts to assure that assumptions were not interjected into the data. Dependability as well as credibility were verified by review of findings with study participants.

The last criterion, confirmability or neutrality (Lincoln & Guba, 1987), was established by the objectivity of the study. The qualitative researcher must provide for unbiased reporting of findings. While bracketing identified researcher assumptions, readers generally familiar with subject areas of the research were used to review transcripts and findings in order to gather feedback about commonly identified themes. Additionally, I was alert to themes outside of my awareness that readers might suggest. Themes or items falling outside groups of data were included in reporting.

Lincoln and Guba (1987) suggested maintaining a journal during the research study as a process review instrument. It provided another "audit trail" (Lincoln & Guba, p. 319)

which can substantiate the researcher's methods, intuition, and process guiding the research. I utilized journal entries to identify feelings about the conversations, note immediate impressions of experience, and mentioned hunches to investigate intuitions or apprehensions of possible meanings.

CHAPTER 4

RECOVERY REALITIES AND PROGRAM PARTICIPATION

This chapter provides extensive description of the recovery program and environment that constituted the context of the study. Although basic description of recovery program information was included in the methodology section, additional information is addressed separately because of the identified importance that involvement in recovery represented to the participants.

Relative importance of recovery participation emerged because this research required participants to retrospectively review their experiences of using drugs while pregnant. Participation in a recovery program supported self-exploration and required women to thoughtfully examine thoughts, feelings, and experiences. This introspective requirement in the program significantly enhanced their ability to recall experience when talking with me. Participants said that talking with me about their experiences was another, similar, exercise in discovery.

In addition, the ability to form new relationships as members of a new group enabled the participants to feel confident in speaking about their lives with me. I had the

sense that some of them were practicing self-presentation with me. For example, a number of women introduced themselves to me as if they were at an Alcoholics Anonymous Meeting, saying for example, "I'm 32 years old, my name is Bonnie and I'm a drug addict. My drugs of choice are heroin and cocaine and I have 2 month's sobriety."

Membership in a recovery program partially defined the women's present reality, and provided a backdrop against which they viewed their experiences. For example, many women could not articulate their prior experience except in contrast to their present experience. They used current experience and insights for contrast in order to understand and appreciate prior experience. Therefore, although consideration of recovery phenomena was not the purpose of this inquiry, it emerged as a significant contributing factor to the experience of the participants.

It is important to note that women in this recovery program were there by choice. Although these women were referred by Child Protective Services, and gaining custody of their children was contingent upon successful completion of the program, attendance was voluntary. Some women never tolerated the entire program, and many women, upon legal separation from their children, did not comply with reunification programs and enter recovery. All of the women in this study had prior experience in at least one recovery program. For the women in this study, attendance

in their current program represented a committed effort to attain and retain sobriety, and to regain custody of their children. Additional discussion explores unique aspects of this research associated with naturalistic inquiry in a recovery program setting.

Recovery Program Description

Description of the program provides an overview of current program activities, expectations, and social setting common to each participant as a member of the program. Each of the study participants is a member of a recovery program primarily organized around women and their children. The recovery program is 1 of 2 identical sites established 2 years ago to address needs of women who have substance abuse difficulties. The goals of the program were to decrease the number of alcohol and drug exposed infants and to ameliorate the effects of perinatal substance abuse by providing education and rehabilitation. The program was endorsed by a variety of funding agencies who supplied fiscal and material support. Four tiers of services existed; day treatment, residential treatment, pregnant inmate programs, and case management services.

All of the women who attended the program were mothers, and most participants attended as mandated by court ordered rehabilitation administered through Child Protective Services. A small percentage of participants self referred.

Participants spent 6 months at the program, arriving on weekdays at 9:00 am in the morning and remaining in the facility about 6 hours. Components of the program included educational classes on drug use and effects, self esteem, parenting, nutrition, and vocational and career exploration. The program provided guidance to achieve a General Education Diploma if participants did not graduated from high school.

A requirement of the program was active participation and sponsorship in a twelve step program, either Alcoholics Anonymous or Narcotics Anonymous. Many women advocated these programs, and felt they benefitted from close relationships with their sponsors.

In addition, each participant developed a close relationship with her program counselor through individual counselling once or twice a week, and daily group therapy sessions. Additional private sessions with counsellors were readily available, as was family therapy.

The program recently extended into correctional facilities so that a woman may begin the program while incarcerated and continue participation when she was released, an experience of several of the women in the study.

The facility was located in a small shopping mall on a busy street. Within the facility there was one large classroom, counsellor's offices, a kitchen, and day care area. Women were encouraged to bring their pre-school age

children to the program, and participants rotated responsibility for child care. It was a crowded, busy place with sounds of children playing, phones ringing, and business being accomplished. Workers and clients circulated in and out of the building all day, smoking in front of the building during breaks, or gathering to talk. Several participants voiced the difficulty they experienced in getting along with so many women at one time, but after hearing personal stories in their counselling groups, they gradually became more tolerant of various behaviors and personalities,

...it takes a lot to be able to get along with a bunch of strange women and deal with them every day...and then, the longer I spent time with them and as you get to know them as people, then you wonder 'oh my gosh, why did they do those things'...they have a lot in their past that I don't even have a clue about and all I can do is be with them, while they're here, and they're admitting that they need help and that's amazing. I have a lot of, I don't know, respect for them. It's all about wanting to be here, somehow. It makes me feel that much more grateful that I was so fortunate, growing up. I took a lot of stuff for granted.

Managing to connect with other women was a particular challenge, as we shall see. For some women, friendships they established in the program were their only memory of close adult relationships with women outside their families.

Counsellors worked closely with Child Protective Services and with the probation department. All women were drug screened on a random basis, and could be discharged from the program for continued substance use. Many women

regained custody of their children while they were participants in the program, and the program acted as an advocate to reunify mothers and children.

About 10 women entered this program every month, and as many left as they graduated, transferred to other programs, or were dismissed from the program. The average age of women in this recovery center was late twenties. Two homes were rented by the program and participants stayed at the homes alone or with their children if they met requirements of sobriety, and if there were vacancies. The homes were unsupervised and provided participants an opportunity to live with their children in a drug free environment. Three women and their children resided at each home. One of the participants in this study lived in the home, and I interviewed her there at her request.

Recovering

"It's all About Wanting to be Here"

Because every woman in the study was in a recovery program, participants voiced some expression of hope for sobriety in the future. Although it was not the purpose of the study to investigate recovery phenomena, it was an inevitable part of participant's experience because they were living it at the time, and is addressed here within that context.

Differences emerged in participant's descriptions and

feelings about their situation depending on their longevity in the program. Generally, those new to the program were concerned about chaos in their lives. The process and program were new to them, and they had many practical aspects of their lives to organize. Dealing with their feelings seemed a new experience, and was very unsettling for some. Those midway through the program were hopeful for the future but wistful about the past. They missed their former lives and friends, but were happy to be free of many negative aspects of their former existence. Their lives progressively became focused much more on their children as they began to positively perceive themselves as competent parents.

Women nearing graduation offered an enlarged perspective on their experience and described experiences with substance abuse and pregnancy from an awareness of the continuum of their lives. They expressed a new realization that while addicted they considered only the moment, and they now considered their future. The women viewed their past against the backdrop of recognition of how much they had accomplished and generally felt optimistic about the future. They were not complacent, always alert to the possibility of relapse, monitoring their speech and thinking, and correcting themselves if they heard "old" ways of thinking emerge. They were interesting and easy for me to converse with because they spoke of their experiences

emotionally and thoughtfully.

Remembering

All women in the study recalled their pregnancies easily although a few women experienced difficulty remembering what they were thinking and feeling during that time because of circumstances of their lives, or because in one instance the pregnancy was a year and a half ago. Scheduling interviews a week apart provided participants an opportunity to remember and reflect on memories of important events that were not available to them during the first interview. Several participants came to the second interview with additional information about their experiences, or with new insights about their lives related to pregnancy or addiction or both.

Participants expressed relief when talking about their experiences because they viewed the ability to talk about their experiences as a sign of recovery. Relief sprang from the freedom to talk about a socially prohibited topic, and from a sense of increasing emotional strength. One participant said, "...when you're starting to feel good about yourself and what you're doing, you want to talk about it." It was common for women to cry during the interview, and to look back with disbelief about their prior behavior and experience, saying "...I was a whole different person then. When I look back, I can't believe the things I did."

Some of their behavior was difficult for me to accept, although I believed them. My initial feelings of anger and frustration toward these women usually transformed to empathy after I heard one story after another of their isolation, destitution, and desperation. This is not to say that my feelings of anger, frustration, and despair did not recur, but I learned to observe and honor them. For example, one woman's addiction to alcohol was so profound I felt myself longing for a drink after our interview. A quick inventory of consciousness revealed the desire for a drink didn't originate with me, but was a reflection of her own desire for alcohol. I learned that day to be very present to my own feelings and note their fluctuations in response to interview data. I noted my response in my journal for that day, and watched for subsequent similar reactions.

All women in the study used drugs prior to their pregnancy. Drugs of abuse were alcohol, heroin, cocaine, rock cocaine, crystal methamphetamine, and marijuana. Several women mentioned abstaining from caffeine and cigarettes in an attempt to be totally "drug free". According to their reports, most women had used multiple drugs (polydrug abuse) over the years, but many used a few drugs such as cocaine and heroin almost exclusively at the time of entry into the recovery program.

Average age of the 12 participants was 34, and although

many had begun to use drugs during a turbulent adolescence, some women started using drugs in their late 20s or early 30s. Some women used drugs (used) because their siblings, friends, boyfriends or husbands used, others used because it was "normal" behavior in their social circle. Some women used drugs because the effects of the drug provided relief from unpleasant emotional states. For example, one woman, prescribed Lithium and Ritalin as a child and into her preteens, described her initial teenage use of marijuana and Valium as normalizing, "...it would make me feel normal, slower, I go too fast."

Connecting

"Connecting" was a recovery phenomena because women felt that their new ability to form friendships and relationships with other people was important and valuable. For these women, newfound pleasure experienced through relationships with others not centered on drug use and acquisition was novel and exciting. This section discusses the phenomena of mutual connection between researcher and participant experienced through engagement in a research project involving conversation and exchange with one another.

Within the parameters of the study, participants connected with me by entering a voluntary relationship to offer their experience and knowledge in order to help

others. In addition, I was another person in their environment with whom they had the opportunity to practice social skills and to tell their stories. As a result of the study process, I have feelings of reciprocal connection with the women because they discussed intimate details of their lives and shared painful and disturbing memories and realizations. A quote from my journal, "Talking to them is in some ways, like being a confessor. I will not divulge their story [breach their confidence], they will not see me again after two discussions. They can tell me anything, and they do."

I feel profound respect for these women who were willing to share their stories and their pain. For these people who needed so much, the wish to give to others through telling their stories was an poignant factor in their decision to participate as this exerpt illustrates,

I hope I can help young people, and also I want others to know not to close the doors to drug addicts. It makes me nervous [talking], but maybe I can be a help to people, anyway it lets people know you can change.

And, "...I hope this does some good, I hope other women get help before I did." Participants often would ask at the end of the interview, "Did I help you?", or "Was that something that would help?" I soon learned to begin our conversations by telling them how valuable I found their willingness to share their experiences. The effort and gesture to help others was clearly an important aspect of

their sense of self and a new experience of connecting with others. I responded to their extension of themselves by wanting to help them, sometimes inappropriately. I did not cross the line of researcher, but I thought about it, as a journal entry divulges:

Today I became aware of a severe rescue fantasy I had with one participant especially. I met her casually as she was serving as receptionist and I was waiting for an appointment. She is so bright, and capable, and wants to do more, and has good insight into some aspects of her life (and sees a therapist) and I thought of myself calling Point Loma College, telling them about her, getting her a scholarship, saving her from technical classes. I found myself giving her advice in the first interview, but caught myself and stayed my distance. It is complicated.

In many instances, I learned that a powerful attraction for me is the possibility of change. I found that information gathered from interviewing 2 women a day was the maximum I could absorb and hold at one time. I used my family, friends and professional associates as supports and shared with them the pain of the women I spoke to. Writing in a journal about particularly moving, confusing, or disturbing moments provided a vessel to decant feelings as well as store material for future review and analysis.

CHAPTER 5

PRESENTATION OF FINDINGS

Experiencing Pregnancy

Occurring simultaneously with drug use, pregnancy was a conscious, welcome and planned event for some women. For others, pregnancy was a disconnected and unwelcome circumstance for those whose lives centered almost exclusively around obtaining and using drugs. Planned or unplanned, the concept of "baby" was universally abstract. Like unaddicted women, these women spoke of bearing children for a variety of reasons. For example, having a baby meant automatic membership in a group called "mothers", a chance to define themselves as someone other than a drug addict. Having a baby sometimes meant producing a partner for an instant loving relationship, or sometimes meant having an unwanted burden to bear. Despite disparate motivations for having children, one factor common to all participants was that the experience of pregnancy was tempered by the presence of drug addiction. When women spoke of their experience of having children, three circumstances of pregnancy emerged: planned and welcomed pregnancies, unplanned and welcomed pregnancies, and unplanned and

unwelcomed pregnancies.

Planned, Welcomed Pregnancy

The decision to have a child is a complex process and varies from person to person. Because individuals differ so greatly, it is possible that no two women arrive at the decision to have a child for exactly the same reasons or in the same way. In this instance, drug use did not deter women from wanting and planning pregnancies. Although circumstances of pregnancy varied with individual women, some women planned and welcomed pregnancy regardless of their drug problem.

Baby as Metaphor

Meaning of the pregnancies were metaphoric to the women because, like unaddicted women, having a baby represented systemic changes in their lives secondary to pregnancy and subsequent arrival of an infant. They expected a crucial element added or changed to their lives, and often that element was related to addiction. For example, several women described wanting to have children because motherhood symbolized responsibility and normalcy, attributes not associated with addiction. Having a child meant producing an extension of self into society, or serving as the means to extend a family, transcending existence via another human being.

Creating a family.

Throughout her life Rebecca felt outside of mainstream society, and responsibility and normalcy were elusive realities. Rebecca stated that she chose to have a baby because she wanted stability and happiness in her life, and because she was ready for a change;

Well, I thought that if I had something to help me be responsible, plus the relationship I was in, it wasn't based on love, it was based on need, and ah, I just thought having a baby would give me something to do, somebody to love me, which I found out that kids aren't...you know, that doesn't really work [laughs] but, I don't know, I just had, growing up, I just had all these ideas about family, and that there was happiness in that. And I wanted that happiness and I thought that having a baby and being with someone and having a family and a home and material things would provide that, and I found out a lot different. It's hard work, you know.

Having a baby to be responsible for represented a possible change in the structure and meaning of her life. She also thought a loving relationship with her infant would be immediate and reciprocal. Rebecca did not believe she needed to forgo drugs to be a good mother or to have a "normal" family.

Extending a family.

Several women wished to have children to extend their families. In these examples, pregnancy and childbearing satisfied a wish for a child expressed by someone in the participant's family circle, a daughter, and a fiancé. Although the women voiced pleasure and satisfaction at

pregnancy, the idea or wish for pregnancy did not originate with them.

Expecting her fiance's first child and already a mother of two children by a prior marriage, Lorraine welcomed her pregnancy. She miscarried a baby eight months earlier, and was excited and happy about this pregnancy, because her fiance wanted a child. "Everyone was happy...", until Lorraine found she could not stop using rock cocaine;

...he [her fiance] sent me a cab, for my doctor's appointments, he'd make sure I had money all the time to get down to the doctor and all that..this was his first child, his first baby she looks just like him. But it was very bad for him. A very bad experience for him, I know he'll never forget it. I know he will never forget it. Unbelievable.

Lorraine's fiance was very concerned about her and the effects of drug use on their baby. She told him she was not using drugs, and continued to use. Among all the women interviewed, Lorraine expressed the most remorse about her drug use and manipulating behavior while pregnant. She credits her fiance with remaining in the relationship and continuing to help her despite many examples of behavior that would have ended the relationship for many other men. In her 7th month of pregnancy, Lorraine sustained a ruptured uterus probably secondary to crack cocaine use, giving birth to a premature infant who survived an emergency cesarean section.

Ramona was a partner in a committed relationship. Married 10 years to the father of her 8 year old, she

decided to have another baby because her daughter wanted a sibling. Although Ramona used heroin for years, she did not see her addiction as a major obstacle to her pregnancy;

...my daughter wanted a brother or a sister so bad, so bad, you know, and I couldn't see myself not letting her have, not giving her one. You know, I think that'd be selfish.

On a methadone program, she continued to use heroin

"...chipping [using small amounts of heroin, subcutaneously], here and there. A little." She thought she could quit using heroin during her pregnancy, but found she could not. During our talks, Ramona often compared herself unfavorably with an older sister, also an addict, who successfully stopped using heroin during her pregnancy. Ramona lied to her husband about the amount of heroin she was using, telling him she was only using a "...tiny bit."

Pregnancies were planned and welcomed despite difficult drug problems. Women were convinced they could initiate and continue pregnancies even though they still used drugs. The desire to bear children was related to an individual sense of responsibility and family interests. Drug addiction was not anticipated as an insurmountable obstacle to successful pregnancy.

Unplanned, Welcomed Pregnancy

Two women did not plan their pregnancies but nonetheless welcomed the event. Because pregnancy led these women into recovery programs, they considered accidental

pregnancy a dual gift of sobriety and motherhood.

Experiencing Pregnancy as a Gift

Susan, surprised by her unplanned pregnancy because she had been unable to conceive for about 10 years, was "...shocked, happy, and scared... [to discover her pregnancy]...it was the scariest time in my life...". She had the sense of being "...responsible for another life, and I didn't want this little being to hurt like I did." She considers her pregnancy a "...gift from God" because it resulted in her eventual withdrawal from heroin and cocaine, and initiated dramatic changes in her life. Without the pregnancy, she speculated that she would still be on the streets, a prostitute, and "...found dead from who knows what, sooner or later."

Like Susan, Valerie wanted her baby once she discovered she was pregnant, but she hadn't planned to have a child. A prostitute for years, she never used birth control measures. Despite the lack of birth control, she found herself pregnant about every five years, saying,

I never used anything. Anything. Maybe when I was 18 I used the birth control pill...that was it. But my kids are 5 years apart, 3 years apart, and I never used anything. I don't know why, but that's the way God did it.

Valerie tried her best to stay clean once she discovered the pregnancy. She did not use drugs for 3 months and then was afraid she could not stay clean.

Knowing she had additional jail time to serve for misdemeanor violations, Valerie turned herself in so she would stop using and help her baby, "I went to jail to clean up because I wanted the baby to be born clean, and I did 50 days, but when I got out I used, and had the baby two days later." She predicted dire results had she stayed on the streets, "If I hadn't gotten pregnant and stopped walking, I'd probably be half dead...still using."

Involved in prostitution and addicted to heroin and rock cocaine, Valerie saw her fifth unplanned pregnancy as the gift of new start in parenting because "I wanted him [the baby], and I haven't been a Mom for ten years...I lost a lot of years." Three of her four children (ages 18 through 6) were adopted by her own mother, and she saw them frequently. She described wanting to quit drugs because of the influence her addiction had on her children as they grew older and became increasingly aware of her activities. Rather than framing her wish to curtail drug use solely for her own well-being, she attributed the wish for sobriety as responsibility toward her family;

I'm getting old and they're getting to be teenagers, and they know so much in school, and they see me high, I never lied to them. I told them what I did. (crying) Well, I have to think about me and them. And if I'm using, what are they going to have? When I first started using and I used to see older drug addicts, I always would tell myself I don't want to be that old and still be using. And here I am old and grey [34], have a new baby, and I'm and still using...and what am I going to be? A 56 year old hype? Then my kids are going to be right behind me using just like these other women. I'd rather die. I've got to do something now,

and if I don't my kids are going to be right there with me. 'Cuz that's all you see.

Unplanned, Unwelcomed Pregnancies

Other women found their pregnancies to be unplanned and unwelcome surprises. Discovering her pregnancy at about four months, Sophia had not noted absence of menses, "When you're a drug addict, you don't keep up with all that." Another said, "...when you're on drugs, you don't notice what's going on." Rhonda reacted to the pregnancy with shock and surprise, knowing she could not control her drug use;

...because when I left there [the clinic where she had the pregnancy test] I was totally in shock...so I went out and used even more because I knew I couldn't give it up and I couldn't quit using drugs so I thought whatever happened would have to happen.

Ashley, a 20 year old crystal methamphetamine user and mother of four, reported that she did not have time to provide birth control for herself, or seek the abortion she planned once she found she was pregnant;

...I was just so into getting high, I didn't have time to do that [use birth control], I didn't have time for anything, I didn't have time to wait in the welfare office for medi-cal, so, you know, the months went by...

Her life was absorbed by acquiring and using drugs, leaving time or energy for little else.

Lisa knew she was pregnant after about four months, "...just the thought of being pregnant, I hated it." Involved in an abusive relationship with an ex-husband and

addicted to rock cocaine, she blamed her pregnancy on his failure to be cautious despite his knowledge that she was not using birth control. She speaks of her feelings about her ex-husband;

I hated him, and I didn't want this child, and I didn't want to get pregnant. It really happened because I asked him to be careful, and he wasn't, and he said, 'Oh, sorry', and I said later 'I'm sorry too, I'm pregnant.'

She and her ex-husband had an arrangement not unique to Lisa. He gave her money to buy drugs, she cared for their children, kept house, and was required to ask permission any time she left the premises. He would not permit her to use birth control because he believed it would keep her from engaging in sexual acts with other men in exchange for drugs. Since Lisa did not believe in abortion and was not using birth control, her only option was to unhappily continue the pregnancy.

Discovering Advanced Pregnancy

Irregular menses were described by many women, and several women found that irregular menses precluded early discovery of pregnancy. Upon discovering the pregnancy, several options were available: abortion, adoption, and keeping the child when it was born.

Considering abortion.

Late discovery made contemplated abortions impossible, and by that time they had been using drugs for the early months of their pregnancies.

Like Alicia, some women considered abortion. She said, "I didn't know until I was like, 6 months because after my last baby I didn't have menstruation...I started gaining weight but I thought I was just gaining weight. I did want an abortion but I was already 6 months."

Most who considered abortion but decided against it were too far into their pregnancies, lacked practical resources to obtain an abortion, or decided they wanted their babies. For instance, one woman went to have an abortion but changed her mind;

I put the robe on and I went in the room with about 25 girls younger than I was, all getting abortions, and the tears were rolling down my face, and God just picked me up, somebody picked me up, I don't know who it was, and I put my clothes back on and I left, and I went over my girlfriend's house, I did a line [of cocaine], and went home and told my fiance that I couldn't do it.

Having several previous abortions because of her addiction, she decided to continue the pregnancy and try to stop using drugs.

Considering adoption.

Colleen said, "I was having irregular periods, so for the first three months I didn't pay attention too much. By the fourth month, I knew this can't be right..and so it took

me about probably four months to know." She kept her pregnancy secret, remembering "...going with blinders on, waiting to run into a wall." She considered adoption, but decided to keep her baby after delivery. She perused the yellow pages a few times during her pregnancy, looking for help. Not knowing what to look for or how to go about adoption, she did not make any calls, "...I never found anything that looked right, so I just let it go."

Ashley intended adoption of her child from the moment she knew she was pregnant. She didn't seek medical care;

...because I knew I was going to put the baby up for adoption...so why should I go see a doctor, I'm not going to raise it, so why should I care? I thought, I don't care, I just ignored the whole pregnancy so once I gave it away it would be easier for me to give away.

She stopped using drugs when she was 5 months pregnant and delivered a infant that she relinquished to adoptive parents in an open adoption program.

Regardless of the planned or unplanned status of the pregnancy, an idea of the state of pregnancy as inhibiting drug use emerged. Women felt that pregnancy would confer the ability to refrain from using drugs. When that ability was not realized, they voiced disappointment and surprise. For women who planned pregnancies and imagined their subsequent abstinence, unrelenting addiction during pregnancy was a bitter experience.

Being an Addict and Being Pregnant

Escaping the Reality of Pregnancy

First knowledge of pregnancy was a private experience. Before the pregnancy became visible, it was possible for women to conduct life as if they were not pregnant. Acting in ways that pregnant women should not act such as drinking in bars, and using drugs forestalled public acknowledgement of pregnancy. Rationalizing drug use and the lifestyle of the drug user contributed to the ability to put off acknowledgement of pregnancy for as long as possible.

Acting "Not Pregnant"

For many women, early pregnancy was an abstraction, an idea without manifest physical reality. Before the fetus moved, and before distinct physical changes took place, it was easy to "forget" about the pregnancy. Susan said, "It wasn't real until I heard the heartbeat [in jail], that made it real right there." As they began to live with the knowledge they were pregnant, some women voiced what at first appeared to be a fatalistic attitude about their pregnancies. Colleen said;

I can remember having thoughts that, well, say I'm drinking, and I got drunk several times while I was pregnant, real drunk. And I thought 'I don't care, I don't care. If it lives, it lives. If it doesn't, it

doesn't.' That kind of thought...I knew I wasn't managing. But I could pretend that I was. And it was more easy to pretend, of course, if there was any kind of dope around.

Acting "not pregnant" was similar to acting "not addicted". Women acknowledged both behaviors as survival maneuvers of denial and their behaviors were reinforced by social and emotional isolation, discussed at a later point. The effects of drugs, as will be seen, enabled these women to blunt painful feelings about their addiction and pregnancies.

Because she had one other child who was born exposed to drugs without apparent physical problems, Rhonda said, "I didn't think about the baby too much, I just didn't." She went on to say;

I'd had a baby before that was born with cocaine in him and I smoked pot the whole time when I had my second child and it was born just fine...and so I continued to get high and had no remorse whatsoever. And had a nice, healthy baby. I just figured I'd fight for him and just lie my way out of it, you know. If I thought positive, I'd get away with it.

Her method of "scamming the system" extended into her pregnancy. She described her life as a "...game of evasion", which apparently included evading detection of her pregnancy. She publicly acted as if she weren't pregnant, for example, when she went to a bar, she would wear a jacket to disguise her pregnancy because "I would see a sign that said, "Don't drink, it might hurt your baby, and my heart would be so sad...because it was really hard for me not to drink, not to use." Giving up drugs during pregnancy meant

giving up her lifestyle, her friends, and her income;

...we'd stay up and go to dances, and go out, and it really was fun and we got limousines, and sniffed coke, and the people, I just couldn't believe it, the people that were the heads of things were in it, it wasn't like skid row or it wasn't bums, it was pretty people, rich people, people who owned places you know, I could make \$500 in one night. And for the rest of my life, that's all gone.

Rhonda had an 8th grade education, and knew her income could never approach what she made dealing drugs. Rhonda criticized social workers who came to her home to investigate 16 complaints of child neglect. The complaints were filed, she said, by women to whom she refused to sell drugs. The basis for criticism was that the social workers could not tell she was high when they visited, and while she won the game by evading detection, she was angry at the system for not sending more "trained" workers into the field, "...they were just so naive, you know." While their naivete allowed her to escape apprehension, she sounded as if she wanted to be stopped, "...I was high and they never knew it, I was 8 months pregnant, and I just think people fall through the cracks." Rhonda was angry with the system, and paradoxically angry she wasn't stopped.

Ashley was able to repel her feelings about the baby because she planned on adoption, "...it was so easy for me to act like I wasn't pregnant up until the second after she was born, and I saw her. That's when it was hard."

Rationalizing Drug Use

Rationalizing drug use was voiced by many women.

"I knew drinking was bad, but I saw other people doing bad things and nothing happened to their babies, so, I just figured nothing would happen to mine", said Alicia. She prayed that her baby would be healthy and continued to drink. "I just couldn't see going through a day without a drink, sober and miserable." She drank between 2 and 3 fifths of liquor every other day for the first seven months of her pregnancy.

The reason I knew it was day or night was the kids...they were up and down, but for me it all ran together, and in my mind deep down I knew I should stop drinking, but I just couldn't.

She didn't think of herself as an alcoholic, and refused to believe she needed help. "I used to have talks with God while I was at home with a drink in my hand. Drinking took the pain away, and then I could sleep." Alicia did not consider herself an alcoholic because she "...still functioned," paid her bills, fed and clothed her children. "People knew I drank, but they never would have thought I'd sit there and drink a fifth of liquor, and still stand up and talk." As long as the facade remained intact, she could deny the issues. She used alcohol "...as a substitute for understanding, for love, or because I couldn't voice my opinion...when I drank, I didn't have to think about it [her relationship with her husband]."

Colleen shared Alicia's opinion of her own drug use.

Like Alicia, she didn't believe she had a problem because she always worked, had a nice place to live, and cared for her older children.

Sophia was 32 years old and at first denied having any feelings about her latest pregnancy. Since age 15, the maximum amount of time she was outside of correctional facilities before being sentenced again was two months. Discovering the pregnancy in jail, she was put on methadone and said, "I just forgot it. Forgot I was pregnant. I was always loaded, so I didn't even notice the feelings." Her feelings about the pregnancy were muted. Our discussion is represented by this excerpt:

M. Before you had the baby, did you worry about him being okay?

S. No, I don't know, to me, he was going to be all right.

M. Were you sick during your pregnancy? Did you have morning sickness?

S. No, because I was stoned. Soon as you wake up you go get your methadone. Methadone makes you nod just like heroin, so it's all I wanted to be doing. All I thought about.

Feelings about her concurrent drug use and pregnancy were negative and largely repelled, "I didn't feel anything because I really didn't care." Talking with Sophia was difficult because when she was not answering a direct

question her attention appeared to wander. She reluctantly made eye contact, but as our interview progressed she became more engaged in our conversation. I felt like I was just one of many, many professional people who had interviewed her about these issues over the years. Some of her answers to questions seemed prepared and rehearsed, and I had a sense of being told what she thought I wanted to hear.

Living Moment by Moment

Drug use permitted some women to forget about their pregnancies, which they considered only one of many problems. The pattern of existence centered on addiction and lived "...moment by moment" contributed to drug use during pregnancy. Pregnancy was not considered an immediate issue needing attention. Attending to pregnancy was delayed because other life events were more immediate or more important. Further, mothers who had prior experience or had heard of other women's experiences with drug exposed infants wanted to avoid Child Protective Services. They were afraid of possible arrest, incarceration, and loss of their children. Rhonda's fears and feelings were representative;

Because the system sucks, you know, it's got the girls so scared, I almost thought about leaving the state to have the baby. I didn't want them to take my baby, I love my kids, and that scared me.

A key word some women used to describe their average days while pregnant and addicted was "bored". Many women stayed at home caring for small children, self-employed as

daycare providers. Lorraine said, "I was doing babysitting five days a week, you would say full time, I got paid every two weeks and as soon as I'd get paid, I'd run off [to use]." A roommate of Lorraine's used crystal, and sold both crystal and crack, so it was difficult for Lorraine to think of much else, represented by this segment transcribed verbatim;

I dreaded it, every day if it was not, if it didn't revolve around my using, if I couldn't get high really I didn't want to have anything to do with anything, only thing I wanted to do was get high. I didn't care then like now I'm on my, at my daughter's school I'm ah, part of the PTA, you know, members, and you know, God, I just shhhhhhhhhh, I didn't want, it was, there was no way about, you know, wanting to participate or anything like that. I'd help her with her homework sometime that all depends, you know, that all depends on the mood that I was in because I was so tired, burnt out from doing cocaine, and um, Oh God, just thinking, you know, about um, the things, you know that I've done, the, the sickness of the disease I have is really really frightening I wouldn't wish it on my worst enemy, honestly because you know, it's no way it's no way for anybody to live you know it's no where near normal you go through so many God, you go through so many ups and downs so many changes just to get your drugs.

She did her "...plottin' and schemin' [sic]..." during the day to obtain drugs to use at night.

A typical day described by Susan was characteristic for many women;

I would fix, and go hustle up some more money, and cop, and fix again...I mean it was crazy, absolutely insane. I would use and use and use until I would drop dead, and be so tired, and sleep, and wake up two days later and start the whole routine over again.

Rhonda worked, dealing drugs, and her house was full of her using friends, "The phone's always ringing, there's a

lot of commotion, but people like me are used to that commotion, and I love it, you know...", and suggesting her ambivalence about her current situation, "...I hate being laid back, and I hate people that are laid back, it's like you are wasting your life away and you could be doing so much more." "Laid back" referred to non-drug using people who inhabit the world, people who work 9 to 5 and live conventional lives. Her contempt for "laid back" people revealed her ambivalent attitude toward her present existence. The contrast between her present reality of daily attendance at a recovery center, school, and caring for her children is contrasted in a quote exemplifying her former experience. She described a typical housewife's day, plus drugs;

Instead of doing two loads of laundry I'd do 10, and then I would eat a couple valiums to make me relax because I knew I was pregnant, and then I would start drinking, and I wouldn't eat, and I'd do a line, and then I'd do another little line, and another little line, and I'd do little lines, but I'd do a whole bunch of them.

Living moment to moment contributed to drug use during pregnancy because drug addiction is time consuming and provides a singular focus for living. Time spent acquiring and using drugs did not leave many spare moments for reflection or consideration of life events.

Seeking Health Care

Despite addiction and attendant vagaries of addicted living, women who abused drugs sought medical attention during their pregnancy. Their experiences varied, some were positive, some negative. Remarkable for their absence was descriptions of contact with nurses.

"I Saw the Doctor, Took my Vitamins, and Used Drugs."

Rhonda saw her doctor, using all the while. She admitted using during the pregnancy of her second child, but she did not tell the doctor about her drug use during her third pregnancy because she was afraid of the consequence of having her children removed. She made all of her appointments, took her vitamins, and used heavily;

When I was getting my prenatal care, instead of doing me in and doing me out [hurrying her through the appointment], He could have looked at me and known why did I only gain 7 pounds when I was pregnant? You know, I mean, telling me that, 'Oh, it's going to be easy for you after you have it because you won't have all that weight to lose.' I quit using drugs 3 days before my appointments, and he would say, 'You're doing fine, you're just doing fine.' He should have just taken more time for people.

The doctor never questioned her about possible drug use. It is difficult to understand why given this information;

I went to him with my first baby, the one who was born with cocaine, and I told him I wanted an abortion because of my cocaine problem, I had tracks all over my arms and I showed him, and said 'I can't stop,' and he said 'I've never seen a baby deformed or hurt from cocaine,' and he said I was as healthy as a horse and said that I'd be fine, and I'd have a healthy baby, and he was right. I never stopped using, I was fine, and I had a healthy baby.

Rhonda described the doctor as "naaiive" and said she felt demeaned when she went back for her postpartum checkup because;

He didn't confront me, he did not look at me he just looked at the floor, it was really hard for me, going back to face him...he delivered 3 of my children and I looked up to him and respected him. The nurses looked at me and he looked at me and I felt like shit. But it was okay because I faced him.

Alicia saw a physician regularly during her pregnancy, and informed him about her drinking;

I told the doctor I have been drinking lots, and probably this baby will be born with two heads or something because I've been drinking a lot, I haven't been eating, nothing, and this baby's just going to be all messed up and he told me, 'God takes care of his babies,' he said, 'just stop what you've been doing and just pray that everything's going to be all right,' and he gave me a hug, and I thought 'oh, it's so easy for him to say and I just went home and started drinking again.

She admitted feeling angry with him later because he had not referred her for help or more carefully investigated her problem. He expressed his sorrow when her infant was born with Fetal Alcohol Syndrome.

Lorraine saw a physician twice during her pregnancy, at 3 and a half months, and again at about 5 months. During the first visit, a practitioner (discipline unclear) determined that her baby felt small. Drug use was not addressed during this initial visit, nor did Lorraine volunteer the information. At the time of her second visit several months later, she was sent to the high risk clinic and was asked about drug use, which she denied. This visit

was without sequelae of further inquiry about her circumstances, toxicology testing, or a Child Protective Service Referral. She did not return until she arrived in an ambulance with complications requiring emergency cesarean delivery two months before her due date.

Ashley saw an obstetrician while incarcerated;

A. All they did was give me prenatal vitamins.

M. Any talk?

A. No, they don't have time for you in jail. Pregnant or not, they don't care. You're there for committing a crime, they treat you like everybody else.

She did not continue seeing a physician when she was released from jail.

While incarcerated, Valerie profited from a program for expectant mothers who used drugs, and learned about the effects of drug exposure on infants, "...they have a lot of programs in the jail now, and that's the way I found out, if I was never to get in trouble on the street, how would I have found out?" She called her mother from jail and asked her to inspect her children for possible problems related to drugs, "...I'd call my mother and I'd tell her, 'Does T. have this, or, is she okay? Check her for this.'"

Ramona saw a physician during her entire pregnancy and informed him she was on methadone. He did not question her about additional drug use even though the counsellors at the

methadone program told him her tests were "dirty" and the presence of other indications might have prompted inquiry;

When I'd go to the doctor, I'd say 'Oh, is everything still okay? Does everything look okay?', and I only gained 10 pounds through my whole pregnancy, and I was telling the doctor, is this normal, is it okay, is there something wrong with me why am I not gaining no weight and then he told me, 'No, you're lucky you're not gaining weight, and as long as the baby's growing, the baby seems healthy and fine, it's okay that you're not gaining weight.' And that would make me feel like, well, everything's all right.

Valerie saw physicians while she was incarcerated, and delivered her baby two days after release after using heroin and cocaine. Her hospital experience wasn't a good one;

...after I delivered the baby and I was going to the recovery room the doctor he turned around and said, 'This is the last time you're going to hold the baby anyway because they're going to take it away from you, you're not going to see your baby any more.'

Her experience with other caregivers in the hospital was conflicted around medications for pain relief after her cesarean and during a postoperative course complicated by infection. "They [the nurses] wouldn't believe that I was in pain, and the medication didn't help."

Rebecca had a positive experience with her obstetrician. She informed him about her history of drug use and made all her appointments. "I took all my vitamins, and ate right, the only thing I didn't do was exercise." Susan's experience with physician care was also positive. Already detoxed in jail, she was referred by her recovery program to a physician who often dealt with addicted women. She said she was "...able to talk to him about my using, and hopes

for staying clean..."

Seeking Alternatives to Addiction

Colleen and Lorraine both thought about investigating health care for their pregnancies and addiction. When she was laid off from a job she held for five years, Colleen lost her insurance and could not afford to pay the premiums independently;

I knew no matter what I was going to have to have something [insurance], and so when I finally found out how much it was going to cost, then I avoided that too...so I just said, 'I can't afford this' so I just won't think about it anymore.

Since her older children were born by cesarean section, she knew she should seek medical attention, but did not, denying both her pregnancy and her addiction. She is amused at her former naivete about recovery because she thought wealth was a prerequisite to recovery and only people like Betty Ford or Elizabeth Taylor could afford treatment;

I did wonder about it [recovery]. Gradually, all this stuff about drugs started coming out in public with these movie stars and all this stuff, then what I thought recovery was, you spend a lot of money and you went to some spa and they feed you well and they take care of you, and when you come out, you're well, and that was it! Like magic! Now I know it's just plain old being willing to live. And I thought, there's no way I can recover from drugs, because I can't afford it.

Pride and fierce independence kept her from appealing to public sources, "I told myself I should be old enough, grown up enough, to take care of my own problems. I didn't want to be a burden to anyone." Colleen did not recognize her

problem with drugs, but Lorraine knew her problem was significant.

Using crack cocaine.

Lorraine made use of drug hot lines during her pregnancy, calling all over the country seeking help. "I called Washington, I called Albany, I ran my phone bill up sky high." During the sixth month of her pregnancy she went to a local treatment center and was told she should be admitted. Lack of funds made inpatient treatment an impossibility, and she didn't go for outpatient care. She relates her experiences using crack while pregnant;

I wondered what [would be wrong with the baby]. I would try to block it out. I would tell myself it's gonna be okay. It would. When I would feel the baby like moving around all kinda like, funny, I would say to myself I would literally psych myself out, tell myself that it would be okay because I wasn't going to do it any more. That's what I would lie to myself and tell myself Lorraine, you're not going to do it anymore, you know, because the baby could be getting sick you know I'd tell myself this over and over again and then when I would go to use the drug I'd tell myself, we call it minimizing, I'd tell myself well you're just going to do a little bit, you're not going to use that much, you know, and ah, it would, one thing would lead to the next, you know, but yeah I did, I would lie to myself and tell myself that ah the baby would be okay just so I could, I don't know, I don't know why because even then my conscience was still killing me and I knew that it wasn't okay but um, when they say mind altering it's unbelievable the way your mind, I mean, forget, I mean, even now it's like my brain still flashes, I can be sitting here talking to you and my mind will click over to something else, you know....

Lorraine was a difficult person to interview because she needed to be continually refocused and at times it was

difficult to follow her thinking. Talking about her experiences evoked painful feelings, and she cried during each interview. She said, "I try to forgive myself now, but it's very painful, and the pain will never really leave me." The appeal of using crack, she said, was a complete numbing effect, "I guess that's what I chased after all the time was the numbness because I got so numb I couldn't move." She experienced life at a "standstill" while high on crack cocaine.

Rebecca offers another description of crack use;

I could not do anything on crack. I couldn't go outside, I was paranoid, when I would smoke crack it shut out the whole world completely. When I would take a hit I wouldn't even be aware of you sitting next to me. Hours would go by like that. And I wouldn't even know. And the high itself was the most intense I've ever felt.

Given the profound separation from the world that crack cocaine produced, it is not difficult to understand why some women did not or could not attend to their pregnancies while in the midst of an addiction to a drug with such intense effects. Further, paranoia induced by habitual crack use further isolated them from information or commerce with the world.

Feelings About Drug Use While Pregnant

As pregnancy progressed and became an obvious reality, it was increasingly difficult for many women to continue behaving "not pregnant." Knowledge and acceptance of

pregnancy while using drugs produced guilty feelings associated with addiction.

Feeling Guilty

Lisa said, "I would feel guilty for a while, but then when my problems came I couldn't deal, and the drug overpowered my thoughts for that baby." She goes onto describe her thinking at the time;

...it would be in my head about the baby, but then it was like, I wanted it...I can remember when I was using it was like the baby wasn't even in mind, it was like I wasn't even pregnant at all. I was always running from something. It was a constant run from something I couldn't deal with, and at the time I didn't know what it was. I tried and tried to control it, when I did think about the baby it was like it was too late and I was always telling myself okay it was getting to the time, and you can stop...but I couldn't. I couldn't stop at all. Soon as one thing hit me, I was running, and I was always running away from my problems, and I couldn't deal with anything and even with my other kids, at the time I couldn't. I used all the way up until the ambulance came.

Guilt about using and the inability to stop using during pregnancy magnified existing feelings of helplessness. A cycle of using, feeling guilty, and using again was perpetuated. Susan said;

...even though I couldn't stop everytime I used there would be a lot of guilt, I remember after I would fix I'd say 'well, I can't do this anymore' and then I would go out and do it again. I'd walk the streets alone, not knowing what to do. Not wanting to get high but getting high. I couldn't hurt my baby, and it just wasn't okay to use. I've never had suicidal thoughts before that time.

Ashley echoed guilty feelings, "I knew I shouldn't but

I kept on doing it. I didn't have any willpower. None whatsoever." Her first child was born exposed to crystal, and she used during her other pregnancies but stopped at 5 months because "something told me to stop." She always intended to use again once the babies were born, "I knew I was going to go back to using as soon as I had the kid." When she began using at 16, she would sleep two nights a week at the most;

When I first started using, that summer I got a job, I'd go for a week straight without sleeping. And I could do that, and I was fine, so I thought. Go to work, and I'd be so fine, and I can't do that anymore. All my customers loved me, and little did they know the reason I was so happy was because I was high.

Being high on crystal meant that she knew exactly what to expect, and that life was, in a sense, simple because it revolved so centrally around drugs.

Feeling Angry

Knowledge of pregnancy is normally accompanied by ambivalence, and these women experienced ambivalence as well. Although many women expressed some negative feelings about childbearing, two women expressed intense anger during their pregnancies, angry feelings that began in their significant relationships but were ultimately directed toward their babies. Lisa, experiencing an unplanned and unwanted pregnancy, said, "I hated him [her former husband], it was like I put off on her, you know, it was like, I didn't want this child and I didn't want to get pregnant."

Lisa still had difficulty expressing anger, but had more perspective on her feelings. She was able to look back on her pregnancy as a time when she was unable to express anger toward her former husband;

I didn't care [about being pregnant and using drugs], it was like I was saying, not wanting this pregnancy, not wanting to be pregnant, I didn't want this baby...I don't believe in abortion, it was sometimes I felt like I wanted to hurt it. And all along that's what I was doing by doing the drugs...and I didn't want to be pregnant, and it's horrible when you think about it...at the time that's the way I felt but now I've learned to separate the things I have toward her father from her.

Lisa's feelings of anger lead to using drugs to anesthetize her feelings of anger and helplessness in her situation.

Rhonda also identified using drugs while pregnant as a way of expressing her anger, in this case toward her fiancé;

When my fiancé found out the first time I used when I was pregnant, he left me, because I was using with his baby...and that didn't help either, instead of trying to help me, he left me, so I was going to use even more because I wanted to get even...and I didn't think about the baby too much, I just didn't, I don't think the babies get hurt that bad.

Rhonda spoke more fully about this aspect of her using drugs, "I just got angry with my fiancé and that's what I did. It seems kind of dumb now."

Although Alicia did not explicitly say she used alcohol while she was pregnant because she was angry with her husband, the message was implicit in what she said;

I was lonely and I was hurt, and then here I was pregnant and going through all this...and there was nothing I could do about the pregnancy..and I thought, damn, I have four kids, and I'm going to be alone..and my husband came and he said 'oh, I'm going to do right

this time,' and he was off doing whatever, and me, I just thought what the hell is going to happen to us. It was just overwhelming. It really was overwhelming.

After a sonogram revealed that she was pregnant with a girl, she said she could "...cope a little more...", because her three year old twin boys and 14 year old son would have a sister. She was unable to offer examples of how she coped other than drinking.

Fantasizing About the Baby

Like most pregnant women, many of these women wondered about their infants, boy or girl, who they would resemble, what kind of personalities they would have, and how life would be to have a baby. Like other mothers, often their fantasies were of a "perfect" child, and like other concerned mothers, sometimes they worried about the impact of their behavior on their infants.

Worrying About the Effects of Drug Use

Women worried about the health and development of their children. They wondered whether their drug using behavior would adversely affect their children, at birth or at a later time. The worry of drug effects provided additional fantasies, almost universally experienced.

Rebecca wondered whether her baby would be healthy, "...and of course I wondered I guess like any other mother, what's she gonna look like, and what kind of personality she

would have. I felt it was a girl. I wanted a girl, and so did her father."

Susan said her fantasies about her baby reached "obsessional" proportions;

...I kept trying to come up with an image of how it would look...I imagined all of my good qualities in this child, I couldn't imagine it being ugly, I couldn't imagine it having any of my defects. I personally wanted a girl, I wanted her to be an angel. I was worried at first, that drugs would affect the baby, I thought she might have damage to her nervous system. But she's okay although down the line, you know, something might come up.

Pleasant fantasies about her baby were a soothing diversion from Lorraine's worry about her infant, "I fantasized, I used all of that to make myself feel better about using drugs while I was pregnant."

I fantasized that the baby would be okay, that it would be a healthy baby, and I fantasized that it was a boy because I have girls, so yeah, I did a hell of a lot of fantasizing, boy did I, and I would talk to myself quite a bit and tell myself that ah, the baby's going to be okay, and you used, and it's going to be okay, it'll be okay, because you know, I just kept lying to myself and telling myself that I would stop...before I had the baby (crying), but I didn't...

Rhonda was frequently able to avoid negative thoughts, reinforced by two prior pregnancies that produced apparently healthy infants, "I knew I'd have a healthy baby, I never thought that I wouldn't. I mean I just never let myself think that I wouldn't." Later in the interview, however, she admitted to being afraid about the baby's health, "I thought he'd come out with four arms and I'd just..but I knew too, that I couldn't quit using..."

Sophia denied thinking about the baby at all during her pregnancy. She did, however, say, "I do remember all I did was count if he had five fingers and five toes, and I do remember I did that."

Ashley had distressing fantasies about her babies. When asked if she had fantasies about her children, she said;

Yes, especially with my first one. I thought 'Oh my God my kid is going to be the ugliest and be retarded and have to wear glasses and look like a geek', and I just kept thinking I couldn't wait until I was six months to have a sonogram, to make sure it was okay.

Ashley coined the phrase "This is my positox baby", when showing me picture of her new infant, a term only she used. "Positox" meant that her child tested positive for toxic substances at birth. Like other terms reflecting advanced technology, "positox" is a clinical appellation that deletes meaningful human aspects of the phenomena. Using this phrase may have been one of Ashley's methods of distancing herself from her situation.

Fantasizing that Pregnancy Would Cure Addiction

As has been noted, failure to stop drug use despite treatment in many programs and/or self determination to stop using drugs did not deter some women from having children. In fact, having a baby became an imagined route to sobriety.

Knowing the seriousness of drug use while pregnant, some women thought pregnancy, planned or unplanned, would be the ultimate force to stop their drug use. Although they

didn't have special plans to enter a program or otherwise manage their addiction, they nonetheless imagined that pregnancy would almost magically provide the means to quit drugs. Such thinking, given prior unsuccessful attempts at withdrawal, was unprecedented and fantastic. The realization through experience of recovery from drug addiction as a long and arduous process was not part of their thinking.

The fantasy, or wish that pregnancy would confer immunity from drug addiction is found in several responses that reflect unrealistic expectations of pregnancy;

Rebecca,

I decided to have the baby. And it was a real struggle to stay clean. I had to stay in the house, not go anywhere...I had no friends, no clean friends...

and Susan,

When I found out I was pregnant, then I had to think, well, 'I can't hurt my baby', and so it was no longer okay to use. Because somebody else was involved...I wanted to stop, because I always told myself that if I became pregnant, that I would stop, you know, and I found out I couldn't.

And Alicia,

I thought it was just you keep telling yourself 'don't drink, don't drink', and just be adamant.

And Lorraine,

I just thought I could do it. Stop when I wanted, really had to, not when I wanted to, when I had to...and I was hoping and praying to God my baby comes out fine...to me that shows how much power a drug had over me, my mind, myself.

These women represented all categories of experience of

pregnancy, planned and welcomed, unplanned and welcomed, unplanned and unwelcomed. For some women, pregnancy and childbirth were linked to the wish for sobriety regardless of variations in circumstances of pregnancy.

Experiences and Images of Self

A predominant and poignant memory for many women was their socially and emotionally isolated and lonely life while addicted. Pregnancy did not alter their isolation. Pregnancy accentuated existing feelings of isolation because caring for one's pregnancy required complex tasks in an alien environment outside normal social boundaries. It was difficult for the women to describe, and not the purpose of this study, to explore the evolution of their isolation. It is discussed because isolation was a significant factor in drug use during pregnancy because isolation insulated women from sources of information, support, and inspiration. For the purposes of reporting findings, the experience of isolating is approached by considering experiences of social isolation and emotional isolation. In lived reality both forms were experienced simultaneously by these women, and separating them is an artifice.

Isolating Lifestyles

Isolating lifestyles permeated the stories of these

women. Despite many different living arrangements, women found themselves without friends they could talk to about their problems. Married women kept their drug use secret from their spouses: women living with the fathers of their children did not share their problems. One woman lived with her sister and even though she considered her sister a close friend, she was unaware of her cocaine use.

Socially Isolating

A factor inhibiting social exchange was the commonly experienced feeling of "being different". A contributing factor was the difficulty these women experienced in identifying and articulating their feelings. Emotional and social isolation combined with difficulty expressing feelings provided an ideal venue for drug use.

Discomfort in dealing with everyday situations was one example of the extreme social awkwardness experienced by addicted women. The difficulty Rebecca experienced exchanging pleasantries with an elderly passerby on a sunny morning illustrated how difficult it would have been for her to interact with the straight world while she was pregnant and using, and how far removed she was from "normal" social interaction;

But this stuff [being straight] is harder, what I'm doing now. I mean just like that man I was talking to when you pulled up. I mean all that kind of stuff is new to me, to talk to a stranger on the street, say good morning, chit- chat, good morning, you know, it was like I felt kinda uncomfortable, but he was nice,

and he wasn't inappropriate or anything like that, but that kind of stuff is hard. With the drugs, I knew, I mean I was with a certain type of people, I knew what they expected of me, I knew in almost any given situation, I chose pretty much the situation I would put myself in, and I knew what I had to do. And I didn't have a lot of fear...just fear of being without drugs.

Ordinary life events most people take for granted were difficult encounters for many addicted women, for all of their prior recent relationships were predicated on using and obtaining drugs. As Rebecca said, prostitution and addiction produced a predictable series of events and expectations. When she was pregnant and not using, she was extremely isolated, staying in her apartment all day. When she was using, her social contacts were exclusively customers, dealers, or users. The common social practice of baby showers, weaving and welcoming baby and mother into society's fabric was sadly impossible, "If I'd have wanted a baby shower, I couldn't have had one. I had nobody to invite." And;

I had no friends, and nowhere to go. The only thing I knew how to do was hang out in the streets and use drugs. I knew I didn't feel good, but I didn't know what to do about it..it wasn't like I had been where I'm at now and I knew that something was missing...

Rhonda's life was also constricted to using and associating with other users. She does not remember feeling isolated, she remembers being entertained by her associates of whom she now says, "I didn't have any friends, they just wanted the drugs I sold." She hasn't retained contact with anyone she knew while using drugs, "...and I have a lot of

emptiness...it's not loneliness, it's just I don't know what to put in there." Abstaining from drug use was only one element requiring change in a complex system of behaviors, attitudes, and relationships. Complicating matters was a "use or be used" mentality perpetuated in addiction, "When you're an addict, it's hard to listen to people because you're so used to lying," rendering well intentioned suggestions from others suspect, further isolating the individual. A segment of an interview suggests Rhonda's relationship with people in her former social circle;

M. Who did you trust? What did you have you could really make a connection with?

R. The drugs.

M. But no people?

R. Sometimes you don't need people. And your head is playing all those games with you.

Alicia's husband was intensely jealous and did not tolerate her friends. When their marriage ended and Alicia discovered her pregnancy, she had few friends, and was too embarrassed about her drinking to confide in them. Keeping problems to herself prevented discussion of her life with others and fostered a diminished sense of connection and commonality with others. She thought she had to be perfect, and if she never talked about her problems, she didn't have to admit imperfection;

Before, I never used to tell people the things I was going through, I was embarrassed...how could he do that

to me, or how could this happen, ooooh thoroughly embarrassing. And ooooh, I didn't want anybody to know, honey, but now, you know, it's just life we go through. Trials and tribulations, and we have to roll with the punches and just try to do better, and learn from our mistakes, and that's what I'm trying to do. sometimes it's hard. sometimes it gets overbearing and I say 'I can't face it, but what am I gonna do', but I can count my blessings. And I do.

Several women felt that staying home contributed to or maintained their ignorance that help was available in the community. "There was no information that got through to me there...", said Colleen, "...and who was gonna tell me?" Life on the street wasn't conducive to enlightenment either. Valerie said, "I never read, I only watched TV, you see stupid things for beer, and smoking cigarettes and stuff."

Ramona said that office work was an antidote to using, because when she worked she didn't use, "You can't use heroin and work at the same time, you just can't do both things." Ramona worked at an office involved with corrections, and she didn't confide her drug use with anyone in her workplace.

Emotional Isolation

Emotional and social isolation were described as occurring simultaneously. By the time these women entered recovery, their sense and experience of isolation was profound. They had few friends, and they experienced their intimate relationships as largely unsatisfying, or nonexistent.

Susan acknowledged a longstanding pattern of isolation, "I tend to isolate, even when I'm with a lot of people. I never did let anyone close to me. I isolated even when I was using." During early pregnancy, one of her most vivid memories was "...the loneliness I was going through." Susan identified early isolative habits as cultural norms. She continued isolation because of shame and humiliation due to a miserable marriage to an addict, and still later she isolated because of her own addiction. By the time she was pregnant she was deep into addiction and estranged from family and anyone who was not using. Change seemed impossible, "...especially because I didn't want to ask anybody for help, or let them know what I was going through."

Lisa said, "There was no one there for me. Not one single person. I didn't trust no one." The result of a chaotic childhood, Lisa said, was an inability to trust anyone. "I was inside of this shell and I just couldn't come out. You know, it was like I wanted to talk, but there was no one to say anything to." She had no transportation and no money to leave the house where she lived with her ex-husband and their children. "I had to ask him to eat, I had to ask if he could take me somewhere." Drug using partners told her to quit drugs because "...they are testing everyone now, and you're going to be in trouble." Lisa's life changed temporarily when she found a girlfriend to share an

apartment with, and stayed clean for 3 months, but her sobriety proved fragile. One night her roommate, also a user, brought crack cocaine home, and Lisa relapsed.

As Alicia's marriage progressed she became exclusively emotionally dependent on her husband for support, and although her husband purported to object to her drinking, he kept her supply of alcohol stocked;

He didn't want no one around me, he'd want to know who I was with and where I was going, you know, all that, so I just didn't bother with people, because he'd scrutinize everybody, and so I just had like a couple of friends, and then we weren't close, because of him, and so over the years it was just me and him, and the kids, and I really didn't have anybody. I was afraid of him, really. My mother was the only one I could have talked to, and she had died.

Colleen experienced remarkable self imposed isolation because she kept her pregnancy secret. Reflecting on that experience, she said;

It was like a big dream [the pregnancy], and it didn't hit me until I saw the baby. That's when it became real. It might have flashed through my mind but I didn't hold any thoughts that had anything to do with that baby in my mind for any length of time. I just wouldn't let myself do that. As soon as any feelings about anything would come up, I got rid of them as quickly as possible. I didn't want to think...I kept this as separate from my whole life as much as possible. I was like wishing it away. Like that was possible. So I never wanted to feel that it was really any part of me, because I didn't want it to be.

She described her mental state as being in a "big, thick fog" for the duration of her pregnancy, and several months after. "I was temporarily insane...", she said, "...it's the only explanation there is." Drug use was necessary to maintain her extreme degree of isolation and denial.

"...I didn't tell my parents, I didn't tell my brothers and sisters, I didn't tell the kids, and when I would use I'd isolate myself completely. I just locked myself in a room and stayed there." Her past behavior patterns when she was pregnant and used drugs distinctly contrasted with present reality of Colleen's life. When asked how she dealt with her fears now, she said;

...now what happens is that I talk about it, now I have a place to go so I have a place to talk about it, and I can talk about it with anybody now, and I don't feel like I'm being a burden, so it's a big difference, I don't feel so afraid because that's what kept me so sick for so long...is that fear, or being afraid, 'what am I going to do?'

Isolation Within a Family

Some women lived with immediate family or others close to them. Despite the proximity of family and what appeared to be an available support system, these women continued drug use while pregnant. Ramona and Valerie were partners in separate committed relationships, Ramona in a marriage and Valerie with a fiance. Although they were in committed relationships, they isolated within those relationships and continued to abuse drugs. Ashley was estranged from her mother and father and lived with her grandmother during her pregnancies. She relates a living situation in which her drug problem was somehow acknowledged, but not discussed, another example of emotional isolation within a family.

Ramona was a partner in a stable marriage for about 10

years, and close to her parents and sister (a heroin addict), she talked to her family about her drug problems. However, she didn't tell them the truth about her drug use, telling them she only used heroin occasionally. They exhorted her to stop using during her pregnancy, or near the time of delivery, "I wish I would have listened to what people were telling me and telling me and telling me..." Her husband, not a drug user, questioned her about her drug use but she convinced him that she wasn't using much and that the baby would not be affected, "...but I was lying. I was lying to him."

Lorraine's fiance tried to curtail her drug abuse by calling her parents. Her parents visited and wanted her to return East with them and enter drug treatment. She convinced her parents that she could and would stop using and believing her, they returned home. Her fiance warned her to quit, and left her several times during her pregnancy when he detected drugs. "He told me that I can stop he said, 'It really is a mental thing, and you have to be stronger than that', and he believed in me when I didn't believe in myself." Her using nearly cost him his job, because he watched her children when she went out at night and did not return until late the next day, "...a lot of days I caused him missing work being paranoid off of drugs and scared to leave out the door and I didn't want to come home."

Ashley lived with her grandmother during her pregnancies, and her grandmother knew about her drug problem. Of their relationship she said, "She knew when my daughter was born I had a drug problem and everything. I don't know what she really thought. I never asked her." And apparently her grandmother didn't talk to her about it either. Acknowledging the problem but not discussing the problem was an element of Ashley's relationship with her grandmother that Ashley finds difficult to understand, "...that she never mentioned it, that surprises me now."

Wanting Friends

As a result of social and emotional isolation, drug addicted women had no basis for friendship other than drugs, and as we have seen, many of these relationships lasted as long as the drug supply or habitual use lasted.

Mistrusting Women

As the women began to resolve isolation through recovery, some expressed a desire to have friends, others did not. A pattern of distrust of women was discerned. If desired, friendships with women were particularly elusive. Rebecca expressed poignant feelings;

I didn't know how to make friends or keep friends. I didn't know why I was having so much trouble with men, and my drug use was just a little part of it. I was having trouble from kindergarten, kindergarten on. When I was a little kid, all I hung around with were boys, and I knew that I could manipulate and all that,

and get things from them, but I also missed having women friends, and I wanted that.

Men were predictable in their expectations, relationships with women a mystery unless they involved drugs. Sophia and Ramona also learned to manipulate men in relationships that revolved around drugs. A segment from an interview with Sophia represents memories of early relationships;

S. Yes, I had two sisters.

M. I guess when I think about little girls growing up, I think of them as playing together, and...

S. Yeah. Well, see that didn't happen with me because like at the age of 11 already I was already being molested...I never knew what it was to be a little kid growing up because I was already busted. You know, I started running away from home at 11, I was already in Juvenile Hall...so I never knew what it was to be a little girl, I never knew what it was to be a teenager, and I'm barely learning what it is to be an adult. I always hung around guys, I could get what I wanted from them.

She described women as "...snakes, you just turn your back and you'll find them in bed with your boyfriend." Ramona misinterpreted my question about having girlfriends or women friends, thinking that I meant lesbian relationships.

Susan grew up in a protected environment and had close

girlfriends during her childhood and adolescence. However, her friendships ended when she moved to the United States and she experienced difficulty finding a niche in a new social network. She also expressed feelings of alienation from women, saying, "...it's hard for me to talk to women...well, I sometimes have to force myself to talk to anyone." Her husband inhibited potential friendships, "...my husband was very jealous, and possessive so I never had any friends, even from my workplace, I never went out to dinner or to anybody's house." She felt trapped because she was miserable in marriage and her culture prohibited divorce, "...and I found myself doing things for him [her husband] even though deep down inside I didn't want to do them, I mean, even to the point of using drugs."

Ashley complained of not having any friends while she was pregnant;

M. When you were pregnant with the last one, and wanting to quit, did you have women friends that you talked to about that?

A. No, they were all using. And if I did have talks..with this one lady, like we'd talk about quitting and I was just doing another one, getting a fix, in the next room, her son's room in fact. Yeah I know I should quit da da da, and I was in the next room getting it again.

She went on to say, "I had no normal friends whatsoever,

not even anyone in Narcotics Anonymous or Alcoholics Anonymous. I didn't have any friends whatever. It was a lonely feeling. Real lonely."

Valerie said she hated herself for using, and had no friends;

M. ...during the time you were pregnant, who were your friends? Who did you talk to?

V. Nobody.

M. Nobody?

V. I used by myself, and this um, I was staying with an old man, and my old man was supporting my habit. I stopped working the street and stayed at home and, he paid for my methadone and whenever I wanted to do coke.

M. Women friends?

V. Not really. I've always been kind of a loner.

Valerie's mother and sister (addicted to cocaine and heroin) cautioned her against using while pregnant, and despite her self-imposed incarceration and best intentions, she was not able to abstain.

Buying and Selling, Dealing with Drug Suppliers

Drug dealers were not friends but contact with them constituted an important social and business exchange in the lives of these women. Surprisingly, some women related that drug dealers were reluctant to, or refused to, sell drugs to

women they knew were pregnant. Some of the women had kind feelings about their dealers although they knew that any relationship they established would end when drugs or money were scarce. Lisa said;

The only people that were lookin' out for me were the drug dealers. They didn't want to sell me the stuff but the only reason they did it was because they knew my husband was buying it. If they knew I was buying it, they wasn't going to give it to me.

They wouldn't sell to her because they knew she was pregnant.

One of Lorraine's dealers compromised, saying, "I'm not going to let you smoke a whole bunch of dope because that could hurt the baby, so she would what you call, issue me drugs, a little at a time." Lorraine said another dealer;

...would go off, he would curse, scream, holler, everything, because the guy really liked me, and his sister, he would tell me all the time about his niece, how the baby died, and it would upset him you could see it upset him so bad and he wouldn't even sometimes sell to B. [Lorraine's girlfriend] because he knew it would be for us to get high together. I would hear it, and that's bad, anything I can't listen to what the dope man is saying, that's terrible. He would not sell it to me because of his sister, he has never forgotten it, she was bad on drugs like I was and his niece died behind it. While I was pregnant his niece died.

"The devil," Lorraine thought, "was saying 'well, you can get it somewhere else.'" And she did.

Ashley had a similar experience, remembering one dealer who wouldn't sell to her while pregnant, "One wouldn't sell to me. I lived with her. She said 'I'm not going to sell this to you, if you want it, get it from somebody else,' so I would."

Ramona's friend was a dealer, and warned her to stop using, saying, "I'm not going to sell it to you anymore, don't think you're going to be coming to me when you're going to have that baby and I'm going to sell it to you." Ramona's response was simply to go elsewhere to purchase drugs.

Buyers and sellers involved in this exchange knew drugs were plentiful and easily purchased from many sources, so refusing a sale was a symbolic gesture. In the economic world of drug use, however, this act of refusal was unusual from individuals who lived on the addiction of others. The gesture indicated that the dealers self-imposed a limit to exploitation.

Accepting Painful Feelings

Self awareness was generally an illusive concept for many women which contributed to continued drug use and difficulty dealing with pregnancy. Generally, denial of or inability to identify feelings contributed to deteriorating self esteem and isolation from mainstream society. Although many women could not specifically remember or articulate their feeling states during pregnancy and addiction, they described their feelings now, contrasting past and present in order to discern a change.

Rebecca spoke of childhood experiences and their influence as an adult;

I knew the things that happened, and what I did and all that, or what somebody else did to me, but I didn't really think about the fear and which made me what I am, and I'm trying hard to reconcile those things.shame and resentment and all that stuff, growing up with...what it made me.

A predominant feature of the work with these women in recovery was enabling them to identify and articulate their feelings by providing a nurturing environment, and by confrontation. Rhonda said, "I've been alone since I was 16 and always had to do things on my own." Despite her flair and bravado, she feels lost, "I am, I'm really starting all over again, and what's so ironic about it is I feel so immature...I feel just like a little girl and somebody stuck me with these three kids." She said she thought identifying her feelings has been helpful in recovery, "I can feel things a lot easier now, it's not all okay, of course, bad things still happens."

Attending to feelings.

Equally difficult for those who experienced and articulated painful feelings was difficulty in coping with those feelings. Drugs were ultimately a solution to either denial of or experience of pain. Susan stated that a helpful factor in recovery was permitting vulnerability, and attending to her feelings without drugs, "...I never faced my problems, never talked about them, swept them under the rug, and when I started using, it felt like a release, and yet it wasn't, because I was just hiding under the mask of

using." Under the rug went not only the problems, but the feelings attendant to problems.

After losing her business and divorcing, Alicia couldn't deal with feelings of embarrassment and failure. "I was embarrassed, 34 and pregnant, and nothing to show for all these years of working. I was hurt and fed up." Drinking "...took the pain away, and then I could sleep." She states that now she knows "I'm important, and I'm good," implying opposite feelings during her pregnancy and prior to recovery. Alicia describes herself as "overly sensitive" and someone who has feelings that are easily hurt, and says she cries "...at movies, watching TV, it's just easy for me to hurt."

Rebecca also describes herself as very emotional, "Now I cry watching Hallmark commercials," and speaks of life without drugs as emotionally unpredictable, "...I don't like it a lot of times. But it's better than not feeling. I get the good, and I have to take the bad with it. But I get the good too." During her addiction, she said, "I felt bad a lot of the time, but I had no idea exactly what I was feeling. I couldn't express myself emotionally." Rebecca identified tendencies to "stuff" feelings of "...self-pity, resentment, fear, and anger." For Rebecca and other women who experienced tremendous difficulty with living with feelings, addiction was especially insidious;

I'd been using drugs and alcohol for so long that when I wasn't using, I just didn't feel anything. Well, a

lot of times I felt real bad and at least while I was getting high I felt better. But the things I had to do to live to use the drugs made me feel so bad that I had to keep using them.

A very attractive, articulate, and bright woman, she said;

I've always had a hard time accepting compliments, except when I was drunk or loaded. It's the only way I could feel secure. And I don't have a lot of self-confidence. I know my self-esteem isn't high either, and I worry about passing these things on to my daughter.

Her response to painful situations, and her methods of coping have changed;

I don't cry so much about stuff going on with me anymore. It's like I'm emotional, and I still have a hard time with feelings. I still feel I'm not supposed to get angry. I'm not supposed to get hurt. If I just act like it's not there it's not real. It's hard to change that.

Using drugs was a convoluted process employed to express anger, "I'd just do little selfish things like if things didn't go my way, well you hurt me so I can't really do anything to you but I'll show you [and use], and ended up hurting myself.

Colleen also used drugs when she was angry, "...I would tell myself that I deserved to be treated better than that, and that was reason enough to go out and buy it. And it made me feel better, temporarily." Her sister found it easier to be near her when she was using because she was "...more sociable, and I didn't talk about my problems so much." Drugs buffered unwanted feelings about her pregnancy, "I wasn't going to feel anything about it if could help it." Regarding her historical pattern of

dealing with feelings, she said;

...part of my problem with everyone was admitting that I was afraid of, oh, anything. When I got out of that relationship [marriage] I was so tough, I thought, I lived through the worst of it and now I can handle anything. And I felt that way. And I didn't do a lot of things I thought I could do. And, I don't think I'm not capable. I just didn't let myself. I set myself up lots of times. But I'm changing...

She perceives herself differently now;

I think that not talking is what keeps us feeling bad about ourselves, whether it's shame or anger or whatever it is, I like the fact that besides the tears, because I always cry when I start talking, is at least I can talk about it, at least I don't feel ashamed about it anymore, and I can talk about it.

Lorraine described drug use as avoidance, realizing she didn't face problems when using. "I'm no longer scared to face those issues now. I can handle life." When she began using drugs, she was at a point in her life where she;

...couldn't talk, I used drugs if I was in pain, if something was bothering me, if I was hurt because I went through a divorce and all, and I didn't want to feel that pain, that was my way of escaping, using my drugs, so I didn't have to feel that pain. I didn't realize that before. I chose to feel nothing.

Ashley used crystal methamphetamine when she was about 15 because "...everyone else was doing it." Although she was not able to directly associate using drugs with her emotional states, she said;

She [her first baby] was due on the 19th of April, and on April 4th my boyfriend and I, not the father of the baby because he dumped me, um, he and I were having fights, but all day I'd been using crystal. I used up till she was born, and I went into his bathroom in his house after we got in this real bad fight and I said, God, please don't let her be born soon, this is the last one I'm doing, went in, did the line, and by 5 o'clock in the morning I felt my water break and I said

"Oh my God" and I knew I had drugs in my system.

Life without drugs is much more difficult because now she has to "...deal with life on life's terms."

Valerie said, "I have a lot of feelings, and I talk about them. Sometimes my feelings get me in trouble, because I tell the truth." Speaking about relationships and dealing with feelings, she said, "...my step dad raped me when I was younger, I've been dealing with this for years, and I used to hate men and hurt them so they wouldn't hurt me first." She related years of difficulty in speaking about personal, painful feelings, "...it took me a long, long time for years, to get it out and be able to talk about it." She still has a hard time identifying her feelings, "I don't know what I want. I know I want to stay clean and sober, but the way I live, it's hard. I don't know how to deal with pain, I cry, or I use."

Summary, Findings

Findings will be summarized within the 3 major thematic phenomena of the study. Integration of information will occur because experience of the participants included experiencing phenomena simultaneously. Phenomenological articulation of the structure of the experience of being pregnant and using drugs concludes the chapter.

Experiencing Pregnancy

Women experiencing pregnancy during addiction had children for a variety of reasons and in a variety of circumstances. Women who used drugs during pregnancy came to the decision to have a child much like women who did not use drugs, and not all aspects of choice could be articulated. Some women reached the decision within a family, others in the hope of creating a family. The wish to have a child to be "normal" was voiced by several participants, implying that the appearance of normalcy would lead to transforming internal change.

Being an Addict and Being Pregnant

In all cases in this study, addiction preceded and complicated the physical and social experience of pregnancy. All women struggled with the conflict between powerful compulsions to use drugs and powerful injunctions not to use drugs. Some women who welcomed their pregnancy regardless of planned or unplanned pregnancy status abstained from drugs voluntarily or complied with withdrawal protocols in controlled situations. Other women continued to use drugs and incurred incessant nagging guilt and feelings of worthlessness and self-deprecation. Negative feelings related to using drugs were temporarily mitigated by the effects of drugs. One woman addicted to heroin did not describe feelings of guilt. Women who had older, apparently

unaffected drug exposed children reported less worrying about using drugs during pregnancy. Negative feelings about pregnancy and conflicted relationships sometimes resulted in anger being displaced onto the expected child through drug use.

Women experienced pleasant fantasies about their unborn children such as wondering about their appearance and personalities. Worrisome fantasies about pregnancy included imaging the negative effects of drugs on the baby. Women also fantasized that pregnancy could support cessation of drug use, as if achieving an external appearance of normalcy would provide interior change.

Psychological phenomena of denial and minimization continued into pregnancy. Denial included reluctance to tell others or actively contemplate their addiction and pregnancy. Insular, constricted lifestyles contributed to lack of information about programs for pregnant women. Fear of detection and/or removal of children was terrifying and prevented women from seeking help. Some women sought obstetric care and outcomes of interactions with care givers were mixed. Some physicians were supportive, others ignored obvious clues to prenatal drug use, a disturbing and disappointing experience.

Experiences and Images of Self

Like the experience of pregnancy, experiences and

images of self were mediated by addiction and extreme social and emotional isolation. Isolation was pervasive and universal for women in this study. Women described profound and acutely painful loneliness.

Lack of social skills or experience in acquiring and maintaining friends other than drug centered relationships produced feelings of detachment and isolation. Women generally did not describe pregnancy and childbirth as a positive physical experience and were somewhat detached when talking about physical aspects of pregnancy. Contrary to mainstream culture, pregnancy was lonely and experienced in isolation. For example, common cultural ritual practices such as baby showers were not part of their experience, and one woman mourned the lack of celebratory events. Women mistrusted others in general, and other women in particular. Effects of drug use were described insofar as they obtained relief from unpleasant feeling states.

The Composite Structure of the Experience of Being Pregnant and Using Drugs

Phenomenology, according to Van Manen (1990) differs from other human science approaches in that phenomenology makes a distinction between appearance and essence. "This means that phenomenology always asks the question of what is

the nature or meaning of something" (p. 184). Offering an account of experienced space, time, body, and human relations as they are lived provides insight into human experience because meaning and nature of experience is described. In this instance, description of the lived experience of the drug using pregnant woman questions popular or stereotyped images and enlarges the perspective of inquiry. What is the nature and meaning of the experience? Using phenomenological techniques of analysis and based on the collective experience of women in this study, a composite structure of the universal experience of being pregnant and using drugs as discovered in this study is articulated:

Being pregnant and using drugs is a physical, intrapersonal and interpersonal transforming experience that occurs within an isolative addicted lifestyle characterized by mistrust of others, risk-taking, deception, and self-deprecation. Use of drugs incurs feelings of guilt and self-hatred while paradoxically assuaging loneliness, and distancing and dissipating negative feelings. A pervasive lack of connectedness to and positive meaning of one's pregnancy manifests itself in the experience of bringing a child into the world not wholly welcomed.

CHAPTER 6

DISCUSSION OF FINDINGS

The purpose of this chapter is to summarize and discuss findings of the study. Major and minor themes will be discussed and integrated. Three significant major themes emerged in the experience of the substance using pregnant woman; experiencing pregnancy, being an addict and being pregnant, and experiences and images of self. Because some themes overlapped, themes will be integrated. For example, it is very difficult to discuss isolation as a discrete phenomenon because the experience of isolation permeated women's experience. Therefore, aspects of isolation will be discussed throughout the chapter. Conclusions derived from the present study that are necessary suppositions for the continuation of dialogue about knowledge regarding pregnancy and substance abuse will be identified in the next chapter.

Experiencing Pregnancy

Pregnancy was a planned, welcomed event, an unplanned welcomed event, or an unplanned unwelcomed event. Williams' (1986) and Pohlman's (1969) assertions that no single or simple route existed that a woman traveled to come to her decision to have a child or remain child free was reflected

in the experience of these women. The reality of having a child was complex and unique for each woman in the study. Regardless of circumstance, having children represented, as Bergum (1989) suggested, a transformative event. For this group of women, transformation also included significant life changes as they chose to enter addiction treatment. Women grappled with profound interior transforming change of both becoming mothers and recovering from drug dependence.

Planned, Welcomed Pregnancy

Most women planning pregnancy said they did so for numerous reasons, and some aspect of their choice was abstract and not available to be clearly articulated. Women who made a conscious choice to have a child gave 2 reasons: to create a family or extend a family. Creating a family meant accepting responsibility for another person, and in so doing, accepting responsibility for self. Responsibility for self included parenting, abstinence from drug use, and commitment to relationships with the infant and/or father. Chesler (1979) stated that choosing the birth of a child represented acceptance of our own existence, an acceptance heard in Rebecca's wish to have "someone to be responsible for". The decision to have a child was a substantial acknowledgement of her own potential and desire for change. Rebecca knew that having someone to be responsible for required that addiction be curtailed, and she thought that

by virtue of committing to have a child she was capable of that transformation. Some women voiced wishing to have a child because it was just "normal" to have children. The wish to have a child to achieve normalcy was not surprising, for nothing is as American as motherhood and apple pie; both are considered wholesome and acceptable in society. In this spirit, Schaef (1985) said that "... no woman in this culture can be a valid human being unless she produces children" (p. 81).

On another level, becoming part of the fabric of society by assuming a role characteristic of women expressed a wish to affiliate with women. Motherhood is a role learned quite early, a role duplicated by daughters (Chodorow, 1978). Rebecca looked wistful when she said her relationship with her mother was strained, and that she wanted women friends but lacked skills in making or keeping friends. Theories addressing women's development (Gilligan, 1977; Gilligan, Lyons, & Hanmer, 1990; Eichenbaum & Orbach, 1989) suggest that women's relationships are vital to social integration. These women generally did not develop strong relationships with other women, and felt lonely and disconnected.

Having a child provided an entre to friendships with women and ultimately proved Rebecca's salvation from drug abuse through entry into recovery. Themes of social and emotional isolation were linked to the decision to have a

child because some women believed that pregnancy would confer relatedness and diminish isolation.

Pregnancy for women who were in committed relationships assumed a different meaning. Both women expressed wanting to have children themselves and for other people; Ramona for her daughter, Lorraine for her fiancé. Bearing a child contributed to significant relationships because producing a child was a gesture of hope for the future. "Such a decision [to have a child] cannot be fully understood until the child is concretely, by choice, in one's life" (Bergum, 1989, p.45).

Unplanned, Welcomed Pregnancy

Some women did not make a decision to have a child, and a decision without action is essentially not a decision. As Sheehy (1974) said;

Roughly 400 times in her life a woman must make a sober choice. Either she will leave herself open to pregnancy, or she will deny her uterus its animating powers. She can never simply not think about it because that in itself is a way of tipping her destiny (p.238).

Women in this study did not make a sober choice, and they tipped their destiny not only by becoming pregnant but also by having a child exposed to drugs. Nonetheless, having a child produced positive results for both women experiencing unplanned, welcomed pregnancy. They were grateful for their children, and retrospectively grateful that childbirth provided entry to recovery programs. Both women ultimately

saw pregnancy as a gift of a child and a gift of a future reality as they moved through recovery and created new lives. Again, motherhood surfaced as a route to normalcy and relatedness: Valerie welcomed a child because a new baby symbolized "starting over" and signified a new beginning of identity through mothering. She was frustrated because her baby was still in foster care and grieved not being able to bring her baby to the recovery program, "...like the other mothers". Not having a baby at the center set her apart from the other participants, and she was frustrated because she sought companionship based on a common experience of motherhood.

Unplanned, Unwelcomed Pregnancy

For some women, a life based on drug acquisition and use promoted carelessness about birth control. They did not observe caution, and they did not seem concerned about the consequences because their use of drugs obliterated any concern. One woman experienced unwanted pregnancy because her partner did not practice birth control. During our conversations, all 7 women expressed thankfulness about their pregnancies because giving birth to a drug exposed infant led them to recovery. Unexpected, unwanted pregnancy led to three avenues of choice; having and keeping the baby, adoption, or abortion. Two of these women relinquished their babies for adoption, and 3 considered abortion.

Being an Addict and Being Pregnant

Cushner (1981) stated that pregnancy behavioral patterns are usually "...extensions of nonpregnant behavior, and they occur within the larger framework of societal, family, and relational problems" (p. 202). For all the women in this study, pregnancy was preceded by addiction, years of increasingly narrowing social and economic options, establishing patterns of behavior not easily changed.

Escaping the Reality of Pregnancy

Johnson (1980) described denial of addiction a common practice among addicts and some women denied both addiction and pregnancy as long as they could. Some women acted "not pregnant", for example, going to bars and drinking while disguising their pregnancy. For women who did not plan or welcome pregnancy, thinking about the pregnancy was intentionally avoided. Because of social and emotional isolation, women did not have friendships that generated discussion or support for issues regarding drug use and pregnancy.

Rationalizing drug use was associated with denial that accompanies addiction as observed by Peluso and Pelsuo (1988). Rationalizing took the forms of minimizing, or intending to use only a little drug, to explaining drug use as something that "everyone" did. Further, if women kept

their homes, supported their children, and paid their bills, they believed they did not have a significant substance abuse problem. For many women, using drugs was a normal part of being with others, some women bought drugs and used them alone, a trend among younger addicts discovered by Harrison (1989). All women struggled with the conflict between powerful compulsions to use drugs and injunctions not to use drugs.

Drug addiction involved risk-taking behavior which progressively became normative. An evolved lifestyle necessary for acquiring and using illegal substances was described as ritualistic (Peele, 1985; Zinberg, 1984; Zoja, 1989), compulsive behavior. Using drugs required a lifestyle in which duplicitous behavior to get drugs, theft to acquire drugs, and deception about using drugs were ordinary behaviors.

Pregnancy occurred in the midst of this consuming, compulsive, ritualistic behavior pattern of addiction. Behavior associated with "beating the system" or evading apprehension for drug use was sometimes extrapolated to the pregnancy experience. For example, some women feared losing their children or criminal prosecution if discovered using while pregnant as noted by Chasnoff (1988) and Morley (1990), yet they risked pregnancy and risked using drugs while pregnant. In order to emotionally mediate this situation, some women minimized drug use, and minimized

thinking about potential risk to themselves or their children when they used drugs while pregnant.

Seeking Health Care

Some women, fearing detection or lack of consideration of prenatal care as a priority, never sought health care. Despite or perhaps because of risk of discovery, other women sought obstetric care. Seeing a physician related to Rubin's (1984) maternal task of seeking safe passage through pregnancy for mother and infant. For some women, keeping scheduled appointments, even when using drugs, was a gesture indicating the wish for all to be well with mother and baby regardless of drug use. Other women sought care because they wanted to know if their pregnancies were progressing normally, and they knew mothers who did not receive prenatal care would be automatically tested for drugs at birth. Still other women attended appointments sporadically because of disorganized lifestyles or fear of detection.

Some women experienced supportive care from physicians, and conversely some did not. Women who were not in recovery programs who told their physicians about substance abuse were encouraged to stop using drugs, but not referred to recovery programs. Women who denied current use but provided an abuse history and symptoms of drug abuse such as little weight gain during current pregnancies were repeatedly assured that their pregnancies were normal and

mother and baby would be fine. A trend identified in literature (Chasnoff,1990; Streissguth et al., 1991) surfaced: physicians were not sensitive to information related to drug use, and did not pursue information about drugs or make referrals to recovery programs. Some women expressed disbelief, disappointment and chagrin because the physician did not notice blatant signs and symptoms of drug use. Failure to recognize or acknowledge clinical signs was experienced by women as rejection and an indication that the physician did not really care about them. Some women who tested positive for drugs in hospitals experienced harsh judgmental treatment from physicians, nurses, and social workers, further distancing them from formal health care.

Seeking Alternatives to Addiction

For 2 women, lack of prenatal care and addiction was directly related to access to care. One woman was told she should be an inpatient in a program for crack cocaine users, but was not eligible for care because although she was working she was medically indigent. Another mother, employed for 8 years but laid off, lost her health care benefits because she was unable to pay the premiums for her family. Fear of burdening others with expenses related to pregnancy and addiction prevented women from seeking care from friends or relatives. Disenfranchisement from formal health care, said Morley (1990) is common among addicts, and

especially dangerous to women because of reproductive issues. For some women, severe functional impairment also noted by Markowitz (1990) and Morley (1990) hampered their ability to seek help. Extreme social awkwardness and anxiety caused even minor conversations with the "straight" world to be avoided, a pattern noted by Peluso and Peluso (1988).

Feelings About Drug Use While Pregnant

Using drugs resulted in guilty feelings which for some women led to more drug use to relieve the pain of guilt. Women described a perpetual cycle of guilt and using to assuage feelings of guilt with drug effects, a cycle identified by Johnson (1980), and Peluso and Peluso (1988). In retrospect, almost all women said they felt guilty and miserable when using drugs while they were pregnant, however one woman addicted to heroin said she experienced no guilt when using. Another woman addicted to heroin experienced guilt although believed her drug was "organic" and therefore not as damaging as other "chemical" drugs. These women had used for years and experienced several intervening pregnancies. While pregnant, they imagined their babies would withdraw from drugs following birth, and assumed the babies would be fine after withdrawal, which might be another example of denial. Some women knew about other children born exposed to drugs without major problems, and

they hoped their children would be unaffected. This was not unrealistic because as noted, use of drugs does not necessarily mean one's child will be adversely affected (Zinberg, 1984; Peele, 1985).

Socially and emotionally constricted lives provided a limited repertoire for expression of feelings. Women spoke of feeling cut off, disconnected, and not related to society or others. Thus, when feelings of anger originated from a woman's relationship with a man, anger was displaced toward the expected child when woman abused drugs. Anger emanating from women's social roles in a patriarchal society was mentioned in the literature by Chodorow and Contratto (1982) and was reflected in some women's experience. Inability to identify or express anger was retrospectively attributed to evolved patterns of social and emotional isolation and is related to difficulty attending to feelings as observed by Khantzian (1985). The relationship between emotional isolation and drug use and how they relate particularly to women's experience is a topic for future inquiry.

Whether the pregnancy was wanted or not, every time they used drugs women worried about the effects of drug use on their unborn children. Additionally, like non-addicted mothers, these mothers fantasized about their babies (Bergum 1989), wondering about appearance and personalities. A predominant fantasy was that pregnancy could cure addiction. Women believed that the state of pregnancy would enable them

to stop using drugs, even if they had unsuccessfully tried many times before. Realization that the belief was erroneous was a difficult process.

Experiences and Images of Self

Years of addiction promoted profound social and emotional isolation. Predictable life circumstances created by limiting choices in most aspects of life compounded by chaos caused by drug addiction created few options for women to explore or exercise. Further, life patterns surrounding addiction precluded intimate relationships. The experience of social and emotional isolation were intertwined and will be presented together.

Social and Emotional Isolation

Most women described pregnancy as an extremely lonely experience. They felt "bad", but at the time they couldn't identify the source of their pain, reminiscent of Khantzian's (1985) theory. Contrasted with women who have baby showers, receive gifts from family and friends, and share joy at the arrival of a new family member, these women were generally not joined by friends or family in welcoming their babies. Pregnancy was a lonely time and experienced in isolation. For example, common cultural rituals such as baby showers were not part of their experience, and one

woman mourned the lack of celebratory events. The traditionally social nature of childbirth (Ahmed, 1981; Bergum, 1989; Oakley, 1979) was different for these women and requires future inquiry.

Evolved social isolation resulted in very limited social contacts usually constructed around drug use. Sharing feelings about pregnancy would necessitate acknowledging addiction and pregnancy, subjects better avoided. Two women felt supported in their pregnancies despite drug use, but they lied to their partners about the extent of their drug use. Morley (1990) felt that using drugs was a "buffer against despair", and provided momentary relief from depression, feelings echoed by these participants. Additionally, Khantzian's (1985) ideas about drug use to mitigate difficulty managing emotional states are echoed in these women's experiences.

Wanting Friends

Women did not trust anyone, and they most definitely did not trust other women. They looked upon other women as untrustworthy and undesirable as friends. Eichenbaum and Orbach (1989) discussed difficulties women experienced in relationships with other women. They posited that societal expectations of women and early dynamics with mothers created difficulties with psychological intimacy in later years. Women's friendships, they said, are tricky endeavors

because women must negotiate boundary issues germane to social and psychological experiences of being women. These issues were articulated by women in the study as they struggled to redefine their relationships with women during their recovery program, identifying anger and competitive attitudes toward other women. During their addiction, women felt mistrust of women was normal. In retrospect, sharing experiences with other women proved key to recovery.

Eichenbaum and Orbach (1989) stated, "Women's role as nurturer and mother has always provided women with the skills and opportunities to relate and not fear emotional connection" (p.31). Motherhood was a route to connectedness to an intimate relationship with a child, relationships with other women, and to society.

Persons who were sometimes described as friends were drug dealers or suppliers, and several women smiled warmly when remembering their contacts. A relationship built on buying and selling drugs constituted the only relationship some women described as necessary, constituting part of the social structure of addiction (Morley, 1990). Dealers would sometimes refuse to sell drugs to women who were pregnant and admonish them not to use drugs while they were pregnant. Women heard the injunctions and did not heed the advice.

Accepting Painful Feelings

Attending to feelings requires identification of feelings. Identification of feelings requires validation of feelings, primarily through social exchange or relationships. Eichenbaum and Orbach (1989) discussed women's relationships as a primary vehicle for development of relationships both merged and individuated. To illustrate, they stated that beginning with the mother-daughter relationship, identity was meshed with (merged) and then differentiated (individuated) from one's mother. As a woman grows to adulthood, friendships can replicate merged and individuated patterns of early relationships. Within this framework, adult women's friendships provide an emotional venue in which to identify and validate feelings, and gain experience in negotiating relationships with others (Gilligan 1977; Rich, 1990).

The women in this study did not affiliate with other women and thus lacked this aspect of relatedness to society through relationship to other women. Extending the thought, for all the women in the study, years of addiction, isolation, and mistrust of self and others contributed to their inability to validate and identify a range of feelings. They learned not to trust or acknowledge their feelings, but to anesthetize feelings through drug use. Use of drugs was a major coping method for attending to and/or

distancing feeling states.

CHAPTER 7

IMPLICATIONS AND RECOMMENDATIONS

This chapter reviews the study's methodological strengths and limitations, discusses implications for nursing, and recommends areas appropriate for future inquiry associated with major thematic findings of Experiencing Pregnancy, Being an Addict and Being Pregnant, and Experiences and Images of Self. Due to the complex and interrelated nature of women's experience and substance abuse phenomena, themes may overlap. Within each theme or synthesis of themes, issues germane to clinical practice, ethical issues, and feminist research are discussed. The major theme of Experiences and Images of Self is a particular focus of importance directly related to feminist issues. Thus, phenomena of social and emotional isolation of women as discovered in this study are specifically discussed within a feminist theoretical framework.

Strengths and Limitations

The study strengths and limitations include those specific to qualitative research, and those specific to this research project. Perhaps the biggest limitation of the

study was the broad topic of inquiry. Each major and minor theme as well as many related topics could generate an entire research program. A major challenge in qualitative research is to establish and respect boundaries of the question addressed without ignoring other salient information that informs the primary area of inquiry. Thus, I found that each question led to many more questions and other relevant avenues of interest. For example, women experienced profound isolation which permeated their experience. How did the isolation begin? What helped them move beyond isolation? How had their relationships with women evolved? Many more questions for future research were generated than current questions satisfied.

Techniques for establishing trustworthiness of naturalistic inquiry outlined by Lincoln and Guba (1985) will be discussed as they apply to this research study. Research methods utilized in this study that addressed transferability, dependability, confirmability, and credibility are reviewed.

Transferability

According to Lincoln and Guba (1985), transferability is indicated by providing "thick description" of phenomena, a thorough account of phenomena. Despite "thick description", naturalistic research does not purport to generalize information. However, research findings might be

applicable to other populations or persons, and trustworthiness of qualitative research is indicated by four criteria as described.

Alluding to trustworthiness and transferrability, Van Manen (1990), said that phenomenological writing comprises "...examples of examples" (p.131). Writing phenomenology, again according to Van Manen (1990), involves intellectualizing experience and trading metaphor for metaphor, attempting to find the common denominator. In order to represent participant's experience, another person might pursue different lines of inquiry to explicate experience and find common denominators. Another researcher might choose different metaphoric examples and identify different themes; both studies would contribute to our knowledge regarding the phenomena. But because of the subjective nature of phenomenology, it is possible that relevant data has been overlooked because of my technique or personal bias. Therefore, findings may not be transferrable to other persons or populations.

Also, findings may not be transferrable because each phenomenological study is unique as meaning is interpreted through one individual's world view. Further, we are fundamentally limited by words to represent experience;

The words are not the thing. And yet, it is to our words, language, that we must apply all our phenomenological skill and talents, because it is in and through the words that the shining through (the invisible) becomes visible (Van Manen,

1990, p.130).

And though limited by words, words are what we have. The instances and metaphors chosen from "thick description" of phenomena might be differently selected by another. "Translation is always interpretive, critical, and partial" (Haraway, 1988, p. 589). Conducting phenomenological research means becoming immersed in the questions being asked, and faithfully representing phenomena implicitly and explicitly. Although I entered the world of the participants for a short time, much was left unsaid and unexplained. Thus, this research constitutes a partial or beginning inquiry into the phenomena of drug addiction and pregnancy.

Dependability and Confirmability

Dependability and confirmability are related to reliability and objectivity. In naturalistic research, measures are taken to provide enough description to represent phenomena. In addition, the researcher maintains an "audit trail" of information about the study and the researcher's technique of data gathering and analysis. Confirmability or neutrality as described by Lincoln and Guba (1985) was established by keeping a journal, articulating assumptions, and by meticulous attention to emerging data. In this study, I used a journal specifically to help me keep track of my impressions, examine

assumptions, and as an organizing tool to track hunches or intuitions about data.

Written transcriptions of interviews as well as introductory information about this study were given to expert readers who provided additional feedback and validation regarding trends and patterns of major and minor themes, further addressing dependability and confirmability of data interpretation. Several suggestions made by outside readers for interview topics were very helpful, and aided me in maintaining researcher stance. Helpful interviews with dissertation committee members followed their review of interview transcripts and provided guidance as we discussed the evolving process of qualitative research. All of these strategies contributed to the dependability and confirmability of this research.

Credibility

Contributing to truth value, credibility of qualitative research as noted by Lincoln and Guba (1985) was attained by interviewing women twice. Women were asked to review data gleaned from the first interview in order to provide an opportunity to correct or interpret information. As stated, they often thought of new information or aspects of experience in the intervening time between interviews.

A limitation of the study's credibility proved to be its retrospective nature. Some of the women interviewed

experienced pregnancy almost a year ago and naturally their memories were not as vivid as current experience would be. I believe that some of the detachment they displayed when speaking of their pregnancy partially due to distance from the actual event. For example, some women said they had to "think a while" to recover and recall experience. A retrospective inquiry perforce put distance between phenomena and discourse. A retrospective approach was chosen because, on the one hand, I wanted to speak to women whose mentation was not affected by drug use. On the other hand, it was sometimes difficult to know what information was influenced by insights during recovery and what was not. For example, did women feel guilt during their pregnancy or did they identify a feeling as guilt after they were drug free and in recovery? I believe a future study involving temporal proximity to the event in question would enhance credibility.

A strength and also a limitation to credibility was participant's engagement in a recovery program. Recovery participation required much energy and attention, hence participant's focus was appropriately not solely on the past but on the present and future. If they were well along in recovery they sought to distance themselves from their addictive past, including pregnancy. When asked what they would say to the person they were when they were pregnant and using, they often said something like, "Goodbye, and

good riddance." Distasteful memories were sometimes difficult to speak about again. On a positive note, many women were excited at their prospects for recovery and voiced satisfaction and pride at speaking about their experiences, as was noted. They described talking about their addiction history and their feelings therapeutic and healthy, signifying another step toward recovery. The more they talked, the more they gained purchase and perspective on their lives, and they were proud to be helping other people. For my purposes, hearing hopeful words about recovery helped balance information about drug using and pregnancy and enabled me to feel positive about the future. Repeated and heartfelt conversations including isolation, despair and abuse were difficult to hear.

Implications and Recommendations

Implications for nursing and recommendations for research will address issues related to nursing practice, ethics, and feminist inquiry and are organized thematically. Major themes are Experiencing Pregnancy, Being an Addict and Being Pregnant, and Experiences and Images of Self. Because of the broad nature of findings and implications of the study, it is necessary to limit discussion to the specific research question of this study. While limiting discussion, salient areas of concern to nursing are discussed using

thematic findings as an organizing framework.

Experiencing Pregnancy

The experience of pregnancy, wanted or unwanted, may bring substance abuse into the health care system at some point during their pregnancy. Their first contact with a health care professional may be the nurse. What can the nurse do to mitigate the problems encountered by the pregnant abuser in a hospital setting or other health care situation? Chisum (1990) recommends being alert for signs and symptoms of drug abuse. Requisite alertness extends to all areas of health care where nurses are involved. Appropriate referrals and interventions begin with a thorough assessment based not just on physical signs and symptoms but a careful review of history and patterns voiced by the patient.

In an inpatient situation, this approach is useful when the patient is in premature labor and experiences a lengthy stay in the hospital, but would also be indicated in an outpatient area. The problem remains of course, that for the majority of users who arrive in labor it is too late to influence behavior during that pregnancy. What are the most fruitful nursing interventions during hospitalization from the perspective of the patient? What can be done to engage the women to consider recovery during hospitalization and what can be done to achieve continuity of care once she

leaves? All these questions lend themselves to further nursing inquiry.

Before physical changes took place, pregnancy was acknowledged by many women as an abstract concept, not a felt reality. Some women spoke of "realizing" the pregnancy when they "saw" their infants via an ultrasound procedure. Perhaps performing early ultrasounds, giving women the "picture" of the fetus might support earlier recognition of the pregnancy and prompt abstinence from drug use. Bergum (1989) mentioned that ultrasound makes the baby more real.

Early ultrasound would only be effective for women who present for prenatal care, however. The challenging question becomes how to entice women into programs in early pregnancy, or before pregnancy, and to consider nursing's role in this process. Programs whose protocols did not automatically require reporting women using drugs to protective agencies reported good (babies born drug-free) outcomes (Chasnoff, 1986). Protocols of not reporting women who keep appointments and have negative drug tests during prenatal care must be agreed upon by caregivers and protective service agencies. Such programs require broad advertisement and outreach.

A paradox in publicizing programs emerged from this study. Women mistrusted others, especially other women. Programs that advertise services with slogans such as "for women, by women" would not be appealing to this population.

When asked what would be appealing about a drug program for mothers, women responded that an effective appeal was to their responsibility for and sense of motherhood of existing children. Women were very fearful of losing children to foster care if their drug use and pregnancy were discovered. Future nursing research would be helpful in identifying other attractive and nonthreatening methods to achieve successful community outreach.

Incarceration proved a valuable educational experience and source of prenatal care for many women. Since this research began, program representatives have entered jails and engaged women in recovery while incarcerated, and offer continued treatment when discharged. For some women, jail constituted the only alternate environment they were exposed to on a regular basis. Information obtained in jail was meaningful to the women and they appreciated educational efforts. One woman called her mother from jail "at least 12 times" to ask her about possible symptoms of toxic exposure in her 3 year old and 6 month old, symptoms she hadn't been aware of before.

Other women thought that inquiring about drug use in abortion clinics would be an effective strategy. Many women, according to this study, seek abortions because they are using drugs. Community literature about prenatal care for addicted women could be well utilized if placed in busy clinics.

If positive changes are to be made in current trends that indicate many infants are born exposed to drugs, pregnant women who use drugs need access to programs they consider safe. Nursing research exploring advertising strategies and the effectiveness of various program practices is needed to create effective options for women in this circumstance.

Being an Addict and Being Pregnant

Opinions supporting detention of pregnant women who use drugs in order to protect interested parties defined as the fetus, the pregnant woman, and society have been forwarded (Greenlaw, 1990; Moseley & Bell, 1991). Another related controversial issue is routine prenatal and perinatal testing for substances (Moseley & Bell, 1991). Both of these issues assume an adversarial challenge between a women's agency to determine her own behavior versus protecting the interests of society.

A lengthy description of the ethical debates will not be described in this paper. However, findings of the study suggest further areas for inquiry. For example, although women said they wanted to stop using drugs during pregnancy, they found it nearly impossible to accomplish abstinence on their own. While their general opinion of the current legal system with regard to child custody issues was very poor, they all acknowledged that some extraordinary external

influence was necessary to stop using drugs. One woman even sought jail time to achieve sobriety. Several situations co-exist to produce an complex situation; women admittedly could not stop using substances, yet no laws exist that declare using drugs while pregnant illegal. Additionally, society is struggling to legally define personhood and the boundaries of responsibility for citizens. For example, recent arguments posed to rescind abortion decisions may impact this situation if the fetus may become legally redefined as a person, making substance abuse while pregnant, child abuse. In this scenario, arrest and detainment of addicted pregnant women would be within the law.

Only one current threat to women using drugs while pregnant was available, that of protective agency involvement in cases where other children are in the home. Unfortunately, in this study, perceived threats of removing current children did not serve as a motivator to stop using drugs but supported an antithetical reaction - avoidance of prenatal care. What would women find effective in deterring drug use while pregnant?

Some authorities recommend prenatal screening for substance abuse. Again, the threat exists if a women is found positive for toxic substances that her children will be taken away. For women who have no prior children, this is not relevant. Further, as stated, it is not illegal for

women to use drugs while they are pregnant. Also, women engage in other legal behaviors also injurious to pregnancy; smoking, exposure to work related toxic fumes, and consume diets poor in nutritional value. What substances will be screened? Who will know when they were consumed? How much was consumed? What actual harm resulted? Would a women abstain from substances if she knew she would be randomly screened during pregnancy, or would she simply avoid care?

One interesting ethical issue was surfaced by a participant. She felt that for every advertisement selling cigarettes or alcohol, alternative information about 12 step programs or informational "spots" about drugs and alcohol should be shown, aired, or published. She likened advertising campaigns to political campaigns, and was angry that unlike political campaigns, the opposing view of not using substances was not mandated equal time. It is interesting that the "opposing" view was assumed to be abstinence from substances, as if it is normal and acceptable to smoke and drink (use drugs). Perhaps the normative view needs to be redefined as drug-free. Nursing can promote this agenda through support for health care policy and patient and professional educational activities.

No easy answers are found in these debates, but a continual dialogue is necessary if we are to discover avenues to successfully divert women from the use of drugs

before pregnancy occurs. Nursing can play an active role in voicing professional opinion to legislatures via health policy statements and in evolving a research agenda to gain perspective on the issues.

Experiences and Images of Self

Social and emotional isolation was a universal, pervasive reality for the women in this study and prevented them from knowing others, and from knowing themselves, "Only through our connectedness to others can we really know and enhance the self. And only through working on the self can we begin to enhance our connectedness to others" (Lerner, 1988, p.9).

Results of this study suggest that patients need and want positive experiences with health care workers. Positive experiences were described as those interchanges with physicians and nurses when the patient felt free to express feelings and fears about her situation and was not exposed to negative attitudes about drug use. For example, women expressed disappointment when physicians did not notice obvious signs of prenatal drug use. Although some women did not say so, their disappointment was an expression of wanting to be confronted. For example, Rhonda complained because her doctor rushed her through appointments, did not provide for the establishment of a relationship, and did not take the time to know her. She said many drug abusing women

experienced "falling through the cracks", meaning that health care workers did not (or could not) take the time to discover their real stories. Some women yearned to be asked about their problems yet avoided talking about their problems, another area of inquiry for future nursing research. How does addiction affect the ability to form relationships? How does this limitation affect women's lives?

Hostile responses from staff did not help women through a difficult experience and further alienated them from sources of support. Further research is needed to explore how we might assist nurses to sensitize their attitudes and develop helpful interventions based on individual patient needs. Research is also indicated to explore physician attitudes and practices related to detection and intervention with the pregnant addict.

Evolving thought about women's development and interaction with the world has increasingly focused on interpersonal relational aspects (Gilligan, 1977; Gilligan, Lyons, & Hanmer, 1990; Lerner, 1989; Young-Eisendrath, 1988). These writers examine different aspects of women's relationships but all agree that within this culture meaning in women's lives exists by being deeply connected in relationship to others. The women in this study did not experience connectedness to other adults and thus did not have a social or emotional matrix of relationships. They

were disconnected and uncomfortable, and they all shared deeply painful feelings of isolation. Realization that relationships were valuable and positive occurred through addiction recovery. Women spoke of forming valuable friendships with other women by talking about experiences and information about themselves they had not shared before. Women spoke of learning to make eye contact with their infants in parenting class, to make eye contact with others during therapeutic support groups, and of other social behaviors attendant to forming relationships, skills they lacked. Another aspect of women's relational reality surfaced when they were asked what would be appealing about programs for pregnant drug users. It was interesting that as mentioned, women felt that a possible successful appeal to pregnant women using drugs would be framed in accord with their positive value of mothering existing children.

This study surfaced many issues related to participant's relationships with others and their experiences of self. If women's reality in this culture is normally grounded in connection to others, the women in this study did not experience typical women's reality. Isolation was the only universally experienced phenomena and affected all of their experience. New drug treatment programs (Kaufman & McNall, 1991; Morley, 1990) acknowledge that substance abuse problems exist in degrees and is not defined in either/or terms of abstinence or use. These programs

seek to establish relationships with clients who present for treatment and acknowledge that social difficulties of addicted persons must be addressed before other changes are expected. The development of relationship aspects of treatment is promising for the treatment of women and supported by findings of this study. Nursing must consider further research in the relationships of addicted women in order to design useful programs of support and change for addicted women. Nursing's health policy agenda must consider preventive education and innovative intervention for drug use and dependence.

A further example of providing relationships for women who have no access to friends who provide emotional connection and social options is a "Birthing Project" established by a former public health administrator. Levine (1992) outlined this program established in Los Angeles for pregnant teenagers in which they are assigned a "sister-friend" to help them through pregnancy and delivery. According to the article, expected rates of toxicity at birth for this population were 20%, and for the 300 women in the program it was "near zero". "Each sister-friend maintains daily contact, helps find anything that's needed, makes sure doctor's appointments are kept and medications are taken" (p.E7). Sister-friends are present at delivery and continue contact after the babies are born. Drug addiction and parenting programs emphasizing women's

relationships produce hopeful outcomes and need the support and involvement of professional nurses who can provide clinical and research expertise in order to establish and evaluate programs.

Implications for Feminist Inquiry

This section discusses implications for potential future nursing research, nursing practice, and feminist agendas based on the findings of this study related to women's experiences and images of self. A discussion of feminist research agendas is germane because nursing has acknowledged and embraced feminist principles of inquiry (MacPherson, 1983; Chinn & Wheeler, 1985) as important methods for nursing science and knowledge. Exemplified by this study, nursing research includes qualitative methodologies which employ feminist principles of research as the following discussion illustrates.

Commenting on recent developments in feminist inquiry, Gergen (1988) thought that feminist inquiry was moving to establish knowledge claims in social process. Rather than fall prey to the pitfalls of objectivist science, Gergen suggests that a unique feminist epistemology can be evolved and suggests several precepts. According to Gergen, feminist knowledge is a commitment to dialogue, participatory in nature, acknowledging it's dependence on social process, and acknowledging social patterns.

Advocating a unique view similar to Gergen, Haraway (1988) suggests that feminist knowledge is "situated knowledge". Situated knowledge, says Haraway, is relational, about communities, not isolated individuals. "The only way to find a larger vision is to be somewhere in particular" (p.590). In her view, "only partial perspective promises objectivity" (p. 583). Further, she suggested that knowledge existed within limits of space and time, and was not transcendent. A researcher utilizing a feminist approach to research is sensitive to the relational position of the phenomena in question;

I am arguing for politics and epistemologies of location, positioning, and situating, where partiality and not universality is the condition of being heard to make rational knowledge claims. I am arguing for the view from body, always a complex, contradictory, structuring, and structured body (Haraway, 1988, p.589).

Feminists embraces the concept that multiple truths exist and the context of the research, including bias of the researcher, influences research findings.

This study was conducted using feminist principles in part because it explored the nature of using drugs during pregnancy using a naturalistic design. For example, study findings resulted from analysis of interviews about women's experience between researcher and participants. Women's experiences were heard in their own voices and manners of speech and were investigated by another woman. Patterns or themes of experience emerged and were explored by both

parties in the interviews. Findings suggested "situated knowledge", and identified trends from women's experience within a "community" of women, in this case women who used drugs while pregnant. Further, I acknowledged my bias and potential influence of bias on data analysis and interpretation. The situated knowledge achieved by this study followed principles articulated by Haraway (1988).

Motherhood is a social process, and some women in the study rejected mainstream society. Conversely, society's rejection of women addicts was attested to by lack of comprehensive programs and preventative efforts. Who is rejecting whom and why? Further inquiry is indicated to explore the social and political context of this phenomena particularly in relation to personal experience and using a feminist framework. Some experiences or trends were not congruent with traditional views of motherhood, and suggest areas for future research. How does nursing approach or reexamine traditional role functioning for men and women? Although active debate focusing on "appropriate" gender roles occurs, further research is needed to explore options and experiences of varieties of choice for both sexes regarding parenting and nonparenting. How does nursing support patients in their reproductive choices?

Morley (1990) encourages consideration of drug abuse beyond the individual. Critical of programs that operate on the principle that drug addiction is a private, individual

sickness, Morley encouraged consideration of drug abuse as a social phenomenon, "However perverse the crack culture, it is nothing if not social" (p.31). Social systems include relationships, a key focus of feminist research. For example, Haraway's (1988) situated knowledge emanates from a position of inquiry within social process and is discovered by examination of social and contextual reality. Van Den Bergh (1991) agrees from a feminist perspective, supporting consideration of addiction within a social system that engenders oppression of women.

Oppression of women in Western culture was addressed by Lerner (1988), who stated that women's facility in relationships with men was in part due to being a member of an oppressed group;

...in relationships between dominant and subordinate groups, the subordinate group members always possess a far greater understanding of dominant group members and their culture than vice versa (p. 6).

Understanding the dominant culture in this situation meant that women learned how to manage relationships with men and with other addicts. For although most women in this study were not involved in close relationships with anyone during their addiction, they were much more comfortable in their relationships with men and other addicts in general. Women negotiated their existence through dependence on men for drugs and material support, and did not have significant relationships with women.

Many implications for nursing practice and research

surfaced related to the findings in this study, and to evolving feminist inquiry. Paradoxical and perplexing information about addicted women's experiences have been discussed. No simple route exists to reach the problems of addiction, drug exposed children, or to understand women's evolving roles in society. As stated, more questions have been generated than questions answered. However, valuable information has been gleaned to describe the experience of these women and to inform future nursing research. An appropriate concluding comment to this study addressing the complexity of qualitative and feminist research is from Haraway (1988), "Feminist objectivity resists simplification in the last instance" (p.590).

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APPENDICES

APPENDIX A
PARTICIPANT BIOGRAPHICAL INFORMATION

Participant Biographical Information

Rhonda was 35 years old and mother of 3 children aged 7, 5, and 7 months. Her youngest 2 children were born exposed to cocaine and methamphetamine. They were free from obvious symptoms or signs of impairment from drug exposure. Rhonda described this pregnancy as an accident, but she kept every prenatal appointment and told her physician about her prior use. She lost her children to foster care when her baby was born and has since regained custody of all her children. She extended her commitment to the recovery center and was finishing her high school diploma. Rhonda was raised in an affluent suburb of a Southwestern city and became an active user of multiple drugs at 14.

Susan was 32 years old. She had one apparently healthy child, 9 months old. Susan began using drugs, heroin and cocaine, at 28 when her husband developed an addiction to heroin. She worked as a legal secretary but lost her job and savings to addiction. She was surprised and happy to be pregnant and discovered her pregnancy shortly before she was incarcerated. Entering a recovery program while in jail, she continued when she was released. She received prenatal care from 3 months through delivery. She hoped to return to work soon.

Lisa was 33 and had 4 children, 1 born exposed to drugs. She was living in a single room occupancy hotel, pregnant with her fifth child. Lisa did not want the youngest child (1 year old) and never sought prenatal care because she was afraid of detection. Lisa's addiction to crack cocaine contributed to the premature birth of a 4 pound, 11 ounce baby, now adopted by Lisa's relatives. After several months in the hospital for treatment of physical problems, the baby spent 4 months in foster care and is now described as "small for her age".

Alicia was 34 and mother of a 14 year old, 3 year old twins, and an 8 month old baby who had signs of Fetal Alcohol Syndrome (F.A.S.). Alicia acknowledged a long standing problem with alcohol and significant family history of alcohol abuse. She was drinking when she conceived and unhappily discovered the pregnancy at about 4 months. Her 3 year old twins were exposed to alcohol during pregnancy and Alicia described them as "hyperactive" but without physical symptoms of F.A.S. She stopped drinking and entered recovery when 7 months pregnant when Child Protective Services intervened due to an incident with her older children. Alicia finished several years of college and at one time co-owned a retail business.

Colleen was 36, and mother of three children aged 14, 12, and 9 months. Colleen finished junior college and held the same job for 8 years until she was laid off because the company was in financial distress. Colleen described her use of alcohol and cocaine as "insidious", lasting about 5 years. Colleen didn't plan on or want this pregnancy, and never told anyone she was pregnant. She investigated prenatal care and discovered she couldn't afford independent payment. She was reluctant to ask her family for help because of their financial situation, and because she wanted to feel like an adult, and "responsible for myself". Colleen had custody of her three children, and only the youngest was drug exposed. Her baby appears unaffected by drug exposure.

Rebecca was 30 years old and had a year old child. Rebecca's drug use began "at beach parties" in high school with alcohol and marijuana and escalated to an eventual addiction to cocaine, crack cocaine, and heroin. Rebecca entered a recovery program after discharge from a psychiatric unit when she relapsed when her baby was about 4 months old. She planned and wanted the pregnancy, used drugs once while pregnant and successfully abstained the rest of the time. She regularly saw the doctor and "did everything I was supposed to but exercise". Rebecca's father's occupation was professional and her mother was a

teacher. Rebecca attended adult school and hoped to become a secretary.

Sophia was 32 and in a recovery program as part of a mother and child reunification program through the Department of Corrections. Sophia has three children, aged 15, 13, and 2 years. Her older children were adopted and raised by her mother. Sophia began using intravenous heroin with her brother when she was 14 and describes her family as "mostly drug addicts." She had a long history of drug related criminal behavior resulting in incarceration. She did not plan on or want the pregnancy. She received methadone, prenatal care, and delivered while incarcerated. She was without drugs for 18 months, a record for Sophia. She was hopeful about prospects for employment and was engaged to be married in 9 months.

Lorraine, 27, was the mother of 3 children ages 7, 4, and 8 months. She began using alcohol socially in high school and cocaine "on special occasions" at about age 23. A friend introduced her to crack cocaine when she was 25, and her drug use rapidly escalated. Lorraine sought help for addiction while she was pregnant but could not afford to enter inpatient treatment. She planned and wanted the baby. She attended a few prenatal appointments. Her baby was born prematurely and is still in foster care. The health status

of the baby was unclear at the time. Lorraine's father was a police captain in an Eastern city, her mother a social worker. Lorraine attended college and hoped to further her education when her children are older.

Ashley was 20 years old and began using methamphetamine when she was 14. She was the mother of 4 children; one lived with his father, one was in foster care, one was adopted, and one died of Sudden Infant Death Syndrome at 4 months. Ashley was in recovery hoping to regain custody of her child in foster care. She did not plan on or want the latest pregnancy, and did not receive any prenatal care. She used methamphetamine daily until she was 5 months pregnant. Ashley grew up in an affluent suburb of a Southwestern city, and was dismissed from the recovery program during this study because of positive drug tests.

Ramona was in a stable marriage, 34 and the mother of two children, one 8 year old, and a 6 month old baby. Ramona used heroin off and on since her early 20s, and was in a methadone treatment program for a year when she became pregnant. While receiving methadone she continued to use heroin and when she gave birth a month early her baby tested positive for drugs. Ramona planned and wanted the pregnancy, and received prenatal care regularly through her pregnancy. She worked during in clerical positions when she

wasn't using drugs, and hoped to eventually find another job because she found working an antidote to using drugs. Her baby was in foster care with her parents and she and her husband hoped for custody soon.

Valerie was 35 and mother of 5 children aged 16, 11, 6, 3, and 2 months. She described a 10 year history of heroin and cocaine use, abstinence for 2 years, and then a return to use. Her 3 year old and 2 month old were born exposed to drugs, but both appeared to be healthy. Valerie's 16 year old was adopted by her former husband, and Valerie's mother adopted the 11, 6, and 3 year olds. Valerie was hoping to gain custody of her 2 month old child. Valerie did not plan but welcomed the pregnancy, and received regular prenatal care and drug education while incarcerated. She used heroin and cocaine the day after she was released from jail and delivered the following morning.

APPENDIX B
SAMPLE INTERVIEW QUESTIONS

Sample Interview Questions

1. How far had your pregnancy progressed when you realized you were pregnant?
2. How did you see your pregnancy at the time you found out you were pregnant?
3. What were some of your thoughts and feelings about your pregnancy?
4. What were some of your important events that occurred while you were pregnant?
5. What people were important to you while you were pregnant?
6. Tell me about your experiences with your pregnancy.

Possible probe questions

1. Can you talk about your experiences with drugs while you were pregnant?
2. What concerns did you have during that time?

APPENDIX C
CONSENT FORM GIVEN TO PARTICIPANTS

Consent Form with Descriptions of Measures
to Protect Patient Anonymity

You are invited to participate in a study of the experiences of women who have been pregnant, and who have used drugs during their pregnancy. I hope to learn about your situation, your experience, and your thoughts and feelings about your experiences during that time. You will be one of approximately 12 participants in the study.

If you decide to participate, I will ask you to talk with me twice about your experiences. The interviews will last from approximately 30 to 60 minutes. The interviews are discussions between us about your experiences. The interview will be audiotaped, transcribed, and analyzed. I will discuss the first interview with you during the second interview to clarify information, and to see if there is any other information you wished to share.

Several benefits are expected to result from the study. The first is to gain information about women who use drugs while they are pregnant. The information could be used to design programs to help women in your circumstances. Further, you would be contributing to understanding women's responsibilities and lives and the choices that are available to women in today's society.

Expected inconvenience to you is taking the time necessary to complete the interview. Additionally, talking about your experiences could make you uncomfortable. If talking about your experiences makes you unusually anxious, a therapist is available to you within 24 hours for support, at no cost to you. Further therapeutic support could be negotiated with the researcher.

Any information obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission, with one exception. The exception is information about current child abuse that must be reported to Child Protective Services regarding your present interactions with your children. Information in this study will be used to complete a doctoral dissertation in nursing. It will be presented to my dissertation committee at the School of Nursing at the University of San Diego. A report of the completed study will be given to participating agencies.

Confidentiality will be maintained by the following measures. One list of names and identification numbers will be made. It will be kept in a locked file cabinet. Only the researcher has access to the locked file cabinet. The audio tapes will be transcribed using only the identification numbers. No names of personally identifying

information will appear on the transcriptions. The audiotapes will be kept in the same locked file cabinet until my dissertation has been accepted. At that time the audiotapes will be destroyed. Using these measures, written transcripts cannot be traced to you. Written transcripts will be retained by the researcher.

The decision whether or not to participate will not affect your future relations with the agency you are presently attending. If you decide to participate, you may decide to withdraw at any time without penalty.

if you have any questions, please ask me. If you have additional questions later, please feel free to contact me at the address or telephone number listed below.

(Researcher's name, address, and phone)

You are deciding whether or not to participate. Your signature indicates that you have read the information provided above and have decided to participate within the limits of the study as described. No other agreement regarding your participation, verbal or written is in effect. You may withdraw at any time without any penalty after signing this form.

I, the undersigned, understand the above explanations and,
on that basis, I give consent to my voluntary participation
in this research.

Signature of Participant

Date

Signature of Investigator

Date